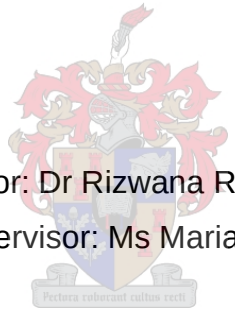
Exploring perceived barriers and facilitators to the delivery of primary mental health care in under-resourced communities in South Africa by registered counsellors in private practice

Greer Maree Salt

Thesis presented in fulfilment of the requirements for the degree of Master of Arts in the Faculty of Arts and Social Sciences at Stellenbosch University



Supervisor: Dr Rizwana Roomaney

Co-supervisor: Ms Mariam Salie

December 2021

DECLARATION

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ABSTRACT

Primary mental health care in low- to middle-income countries, including South Africa, is hampered by a lack of resources, including a lack of human resources. The registered counsellor is an academically trained mid-level mental health professional tasked with the provision of primary mental health care to communities. The introduction of this category was an attempt to close the treatment gap between South African communities in dire need of primary mental health care and the lack of human resources to do so. By 2017, however, almost half of these community-oriented mental health professionals were in private practice, and focusing on one-on-one counselling interventions, largely in urban areas. The purpose of this study was to explore whether registered counsellors in private practice could and did provide primary mental health care from their practices. In particular, the study explored the barriers and facilitators to the delivery of primary mental health care to diverse and under-resourced communities in South Africa by registered counsellors in private practice. The study was conducted among 19 registered counsellors in full-time or part-time private practice. Purposive and snowball sampling were used to recruit participants for the study. Thematic analysis was employed to analyse the data generated by the semi-structured interviews. The study used the Capability, Opportunity, Motivation (COM-B) model and the Theoretical Domains Framework (TDF) to frame and understand the data. The study found that the facilitators of the delivery of primary mental health care by registered counsellors in private practice related to their capability and motivation. Key facilitators included adequate training, knowledge, skills, interest and passion to provide this service. The barriers to providing primary mental health care were related to the lack of physical and social opportunities. The key barriers were the lack of employment opportunities in the public sector, and the lack of knowledge, recognition and engagement by government, other mental health and health professionals and communities. The barriers identified the areas where interventions can be implemented to ensure that the registered counsellor, a necessary mental health professional and resource, does not remain untapped, worse still, disappear.

OPSOMMING

Primêre geestesgesondheidsorg in lae- tot middelinkomste lande, insluitend Suid-Afrika, word belemmer deur ‘n gebrek aan hulpbronne, ook menslike hulpbronne. Die geregistreerde berader is ‘n akademies-opgeleide middelvlak geestesgesondheidsorg professionele persoon wat opgelei is om primêre geestesgesondheidsorg aan uiteenlopende en behoeftige gemeenskappe in Suid-Afrika te verskaf. Die instelling van hierdie kategorie was ‘n poging om the behandelingsgaping tussen Suid-Afrikaanse gemeenskappe met ‘n dringende behoefte aan geestesgesondheidsorg en die onvoldoende menslike hulpbronne te verminder. Nietemin, teen 2017, was amper die helfte van hierdie gemeenskapsgeorienteerde geestesgesondheidsorg professionele persone in privaat praktyk, met ‘n fokus op individuele berading, en hoofsaaklik in stedelike gebiede. Die doel van hierdie studie was om vas te stel of geregistreerde beraders in privaat praktyk primêre geestesgesondheidsorg kan of wel verskaf vanuit hulle privaat praktyke. In besonders, ondersoek hierdie studie the hindernisse en fasiliteerdes wat geregistreerde beraders in privaat praktyk ondervind wanneer hulle poog of slaag om primêre geestesgesondheidsorg aan diverse en behoeftige gemeenskappe te verskaf. Die studie is uitgevoer onder 19 geregistreerde beraders wat voltyds of deeltyds privaat praktyke bestuur het. Doelgerigte en sneeubal steekproefneming is gebruik om deelnemers te werf. Tematiese analiese is ingespan om die data van die semi-gestruktureerde onderhoude te analiseer. Die studie het die “Capability, Opportunity, Motivation” (COM-B) model en die “Theoretical Domains Framework “(TDF) gebruik as raamwerke om die data vas te vang en te verstaan. Die studie het gevind dat die fasiliteerders van die verskaffing van primêre geestesgesondheidsorg deur geregistreerde beraders in privaat praktyk verwant was aan die vermoë en motiveering van geregistreerde beraders. Hoof fasiliteerders het voldoende opleiding, kennis, vaardighede, belangstelling en passie om hierdie diens te lewer ingelsluit. Die hindernisse was verwant aan die gebrek aan fisiese en sosiale geleentheide om hierdie diens te lewer. Die hoof hindernisse was die gebrek aan werksgeleenthede in die openbare sektor, en die gebrek aan kennis, herkenning en betrekking deur die regering, ander geestesgesondhiedsorg- en gesondheidsorgprofessionele persone, en gemeenskappe. Die hindernisse het die

gebiede geïndentifiseer waar intervensies kan plaasvind om die geregistreerde berader te betrek sodat hierdie belangrike menslike hulpbron nie verdwyn nie.

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Chapter 1

Introduction, Rationale and Aim of the Study

1.1 Introduction

The incorporation of mental health care (MHC) into public health care (PHC) was one of the initial endeavours of the National Department of Health (NDOH) after the election of South Africa's first democratic government in 1994 (De Kock & Pillay, 2017). At this time, as a result of the country's previous apartheid government, most psychologists were in private practice and servicing an exclusive community (Pillay & Petersen, 1996). The integration of MHC into PHC was embedded in the Mental Health Care Act no 17 of 2002 (South African Government, 2002), and the intention of this strategy was to lessen the treatment gap between those in need of mental health care and the inadequate resources to do so (Lund et al., 2012). The decentralisation of MHC into PHC meant that fewer hospitals specialised in MHC, but it did not ensure a concurrent increase of mental health facilities in under-resourced communities, or more effective delivery of MHC to these communities (Bateman, 2015). To date, this undertaking is challenging as a result of the insufficient budget for MHC, the inadequate mental health resources and large patient numbers (De Kock & Pillay, 2017).

In South Africa, a middle-income country, research indicates that one in three people endures mental health conditions (Rouillard et al., 2016). This situation impacts negatively on related disability-adjusted life years (DALYs) of South Africans, and on the socio-economic status of individuals and their communities (Prince et al., 2007). Furthermore, this high rate of untreated mental health conditions contributes to the already large burden of infectious diseases and non-communicable diseases (NCD) (Myers et al., 2019) such as cancer, cardio-vascular and chronic respiratory diseases (Selohilwe et al., 2019). Yet, most South Africans still cannot access essential, inclusive mental health services (De Kock & Pillay, 2017). This situation is also the case in other lower- to middle-income countries (LMICs) where 75% to 85% of populations suffer from mental, neurological and substance use disorders (MNS) and received no treatment (Dos Santos et al., 2016). In Mozambique, for example, the treatment gap for mental health conditions is partly due to a lack of human resources (Dos Santos, 2016). The emerging mental health systems in low- and middle-income countries (EMERALD) research programme, which aimed to improve the mental health outcomes in six LMICs, i.e., Ethiopia,

India, Nepal, Nigeria, South Africa and Uganda, established that mental health human resources and mental health facilities were insufficient (Petersen et al., 2017).

In South Africa, furthermore, there are dire socio-economic challenges in many communities, which include unemployment, poverty (Mamabolo, 2015) and violence (Matlala et al., 2018). These factors contribute to a rise in mental illness (De Kock & Pillay, 2016). Other variables such as a lack of awareness and information about mental health conditions also impede the provision and promotion of mental health to low-resourced communities in South Africa (De Kock & Pillay, 2016; 2017; Pillay et al., 2013).

By 2014, it was established that there were 2786 registered clinical psychologists in South Africa. 1213 of these psychologists were working in the public sector at the rate of 2.6 per 100,000 population (Day & Gray cited in De Kock & Pillay, 2017). Despite this, research revealed that there were 466 psychologists and 646 psychiatrists too few in the country (Bateman, 2015). This inadequate human resource (De Kock & Pillay, 2016), as well as the unfilled positions of psychologists and psychiatrists (Pillay & Laher, 2018) impacted on the already overburdened and ineffectual mental health services in the country.

A remedy for the under-resourced mental health services in South Africa was not merely the training and appointing of more psychologists and psychiatrists. What was required was also the training of general mental health professionals who, under supervision of more highly-trained mental health experts, could assist with the detection and management of mental health conditions (Bateman, 2015). The category of Registered Counsellor (RC) was signed into law in 2003 (Elkonin & Sandison, 2006), and was an attempt to address the treatment gap between the lack of human resources and the population in need of MHC in the country (Burns, 2011). The RC qualified as a mental health professional after a four-year academic training in psychology and a six-month practicum / internship with supervision (Abel & Louw, 2009). It was envisioned that the RC would provide primary psychological services in diverse and under-resourced communities, which, among others, included the military and police services, hospitals, primary health care centres, and non-profit organizations (NGOs). Their focus would be on promotion of mental health, prevention of mental health conditions**,** and community-based care. They would provide supportive counselling, psycho-education, basic screening and assessment,

and appropriate referrals to individuals and communities (HPCSA Form 258). Despite sufficient training and preparation, however, research has revealed that RCs in South Africa found it very difficult to secure employment, especially in the public sector in the field of mental health care (Abel & Louw, 2009; Fisher, 2017; Rouillard et al., 2016).

1.2 Rationale

The RC category was deemed a necessary mid-level mental health profession in the development of professional psychology in South Africa (Pillay, 2016). The intention was the creation of many positions for these mental health professionals by the Department of Health These positions would facilitate the provision of primary mental health services for the many impoverished communities that relied on government health services (Pillay, 2016). With a third of South Africans struggling with mental health conditions, this endeavour would have been hugely beneficial to and supportive of health and social rehabilitation in communities (Pillay, 2016). In particular, the RC would increase the capacity of the overburdened human resources tasked with the delivery of mental health services, and would provide the first line of psychological support in communities (HPCSA, 2019). RCs would make MH services more affordable and accessible, and would, alongside supportive counselling, engage in psycho-education and the promotion of psychosocial well-being in communities (HPCSA, 2019).

The category, however, floundered, and the anticipated roll-out of RCs in the public sector did not happen (Pillay, 2016). Instead, a recent study revealed that almost 40% of RCs worked in private practice (Fisher, 2017). The study conducted a survey among 687 RCs in South Africa, and established that the 40% that were in private practice worked in urban areas which included Gauteng, Cape Town, Port Elizabeth and Pretoria. RCs in this study reported that there were very few or no employment opportunities available to them, and that the few employment opportunities that were available paid low salaries, resulting in their funnelling into private practice (Fisher, 2017).

To date, there is no specific study that focuses on whether RCs in private practice can and do comply with the original intention of the category, i.e., the provision of community-based basic MHC to disadvantaged and under-resourced communities in South Africa. The current study could, therefore, fill the gap between the intention of the category and the reality of the current practices of RCs in private

practice. It is, therefore, anticipated that this study will cast some light on whether RCs in private practice do provide basic MHC to the under-resourced communities in dire need of these mental health services, and, in particular, what the barriers and facilitators are that these mental health professionals experience in relation to this task.

1.3 Research question, aim and objectives

1.3.1 Research question

What are the barriers and facilitators that registered counsellors in private practice experience in their delivery of primary mental health care to diverse and under-resourced communities in South Africa?

1.3.2 Research aim

The aim of the study is to identify and explore the perceived barriers and facilitators in the delivery of primary mental health care to diverse and under-resourced communities in South Africa by registered counsellors in private practice.

1.3.3 Research objectives

1. To explore and describe the current practices of registered counsellors in private practice in South Africa.
2. To explore registered counsellors' perceptions of their knowledge and skills as barriers and facilitators in the delivery of primary mental health care to diverse and under-resourced communities
3. To explore registered counsellors' perceptions of elements of their environment as barriers and facilitators in the delivery of primary mental health care to diverse and under-resourced communities.
4. To explore registered counsellors' perceptions of their motivation to deliver primary mental health care to diverse and under-resourced communities.

1.4 Organization of the dissertation

Chapter 1 contains the introduction, rationale, aim and organization of the study. In this chapter, I introduced the research topic and describe the current status of mental health care in South Africa.

Chapter 2 contains the literature review and the theoretical frameworks that I used in the study.

Chapter 3 comprises the methodology that I employed to answer the research question, and includes the research design and setting, the data collection process, the data analysis, and ethical considerations.

Chapter 4 contains a description of participants and the presentation of the findings of the data analysis.

Chapter 5 is the discussion of the findings, where I locate the findings from my study within the broader body of research in the field and the theoretical frameworks that I selected for this study.

Chapter 6 is the final chapter, and includes a summary of the key findings, limitations and recommendations of the study, and the conclusion.

Chapter 2
Literature Review and Theoretical Framework

2.1 Introduction

This chapter is a review of the literature that pertains to primary mental health care (PMHC) in low- to middle-income countries (LMICs), as well as the barriers and facilitators in the delivery of PMHC in these countries, and the role of health workers in this endeavour. I have grouped the results of the review into two sections. The two sections are 1) primary mental health care in low- to middle-income countries, and 2) registered counsellors in South Africa. I conclude the chapter with a description of the theoretical framework that I used to frame my study.

2.2 Primary Mental Health Care in low- to middle-income countries

2.2.1 Mental health

Mental health is a vital element of health, not merely the omission of mental illness. It is a state of well-being from which people develop their potential, effectively manage their lives and related stressors, work efficiently, and engage and contribute to their communities (WHO, 2018). Challenges to mental health emanate from psychological, social and biological fronts, and include stress, discrimination, violence, marginalisation, illness and unhealthy ways of living, and genetic disposition (WHO, 2018). To prevent the development of mental illness, a result of the challenges to mental health, it is important to establish an environment that is supportive of mental health (WHO, 2018). Recent research indicates that the global burden of mental illness is responsible for 32% of years lived with disability (YLDs), and for 13% of disability-adjusted life years (DALYs) (Vigo et al., 2016). In LMICs, 76% to 85% of people who suffer from mental health conditions do not receive treatment for mental health conditions. (Dos Santos et al., 2016; WHO, 2017).

2.2.2 Primary Health Care

Primary Health Care (PHC) is the most efficient, affordable, inclusive and fair strategy to provide care for the physical and mental health, as well as the social well-being, of individuals and communities. As PHC is committed to social justice and multi-stakeholder engagement, it insists on comprehensive health care as a fundamental right of all people without exception. People are the focus of PHC, rather than just particular diseases, and its goal is comprehensive life-long care for the health needs of populations (WHO, 2021).

The essential principles of PHC were initially promoted in the World Health Organization's (WHO) Declaration of Alma-Ata of 1978. This was the first call for global action to implement PHC in all countries (WHO, 2018). In 2018, forty years later, at the WHO's Global Conference on PHC, in Astana, Kazakhstan, global leaders and stakeholders from governments, the private sector and civil society reiterated that PHC was the way to achieve universal health cover (UHC), and Sustainable Development Goals, and thus renewed their commitment to this strategy. In the Declaration of Astana of 2018, these parties tabled four broad commitments which included sustainable PHC that could be adjusted to the context of each country, the promotion of self-care and self-reliance of individuals and communities, and the alignment of stakeholders and national policies (WHO, 2018).

PHC, therefore, affords the individual and communities access to essential universal health care that is accessible and affordable. As an integral element of a country's health system, it provides populations with their first point of contact with the national health care system, and is located in close proximity to their homes and places of employment. PHC includes the promotion of health, the prevention and control of health problems, the treatment of disease and injury, rehabilitation, palliative care, and the supply of crucial drugs. PHC encourages the engagement of local, national and other relevant resources, as well as the full participation of the individual and communities in the planning and management of their own health care (WHO, 2004).

PHC also contributes to the resilience of national health systems in times of crisis, facilitates the detection of initial indications of epidemics, and helps prepare the health systems to act early when there is an increase in the need for services during crises, such as the COVID-19 pandemic (WHO, 2021).

2.2.3 The integration of mental health care into primary health care

The integration of mental health care (MHC) into PHC services, a basic health care recommendation of the WHO (WHO, 2001), has been promoted as a strategy to reduce the treatment gap between those in need of MHC and the limited resources, including human resources, to provide this care (Patel et al., 2013; Petersen et al., 2017; WHO, 2013). Thornicroft et al. (2016) defined integrated PMHC as the practice of promoting mental health for a local community by responding to their particular needs in accessible and appropriate ways, harnessing the resilience of those who suffer from mental illness, and providing sufficient

resources and support, as well as services that are evidence-based and focus on rehabilitation.

Mental health services in PHC settings include the diagnosing and treatment of people with mental health conditions, and the developing of strategies for the prevention of mental illness. It also promotes the training of primary health care workers to develop counselling, interpersonal and interviewing skills so that they can assist people and facilitate positive mental health outcomes for populations (WHO, 1990). Research has shown that MHC can be provided effectively in PHC settings, and that most mental illness is cost-effectively treatable (WHO, 2008). Furthermore, improved collaborative care for common mental disorders (CMD) in PHC settings would provide mental and physical results, as well greater access to affordable assistance.

2.2.4 Primary mental health care in low- to middle-income countries

Mental, neurological and substance use (MNS) disorders have proved to be leading causes of the global burden of disease, and contribute to 32% of global years lived with disability (YLD) and to 13% of disability-adjusted life years (DALY). This indicates that mental illness contributes as much to the global burden of disease as do cardiovascular and circulatory illness (Vigo et al., 2016). In developing countries, an average of 35% to 50% of people with MNS disorders do not receive any treatment (Dos Santos et al., 2016). In LMICs, this number is much higher with 75% - 85% of people untreated for MNS disorders (Dos Santos et al., 2016; WHO, 2017). Despite this burden being carried largely by LMICs, and the fact that there are effective and affordable treatments for some of these disorders (Patel et al., 2007), LMICs do not enjoy the necessary resources or research to manage this challenge (Davies & Lund, 2017). Resources required for MHC in LMICs include human and financial resources, infrastructure, policies, and community resources such as non-governmental organizations (NGOs), social networks, and user and family associations (Saxena et al., 2007). Furthermore, although MNS disorders account for 8,9% of the burden of disease in LMICs (30.1% when mortality is not included), the health budgets in these countries are highly inadequate for the prevention and treatment of MNS disorders (Semrau et al., 2015).

2.2.4.1 The treatment gap

The lack of adequate funding, along with the critical scarcity of mental health treatment personnel, the inadequate services (Davies & Lund, 2017), and the inept

way of engaging existing services (Saraceno et al., 2007), contribute to the significant treatment gap of mental health service provision (Semrau et al., 2015). The treatment gap, more specifically, alludes to the development that very few people with MNS disorders in LMICs experience any form of treatment, while an even smaller number receive required MHC that is sustained and co-ordinated, as the demand for MHC far outweighs the available services and human resources (Davies & Lund, 2017; Selohilwe et al., 2019; Semrau et al., 2015). This inadequate response, at the system level, is determined by political agendas and the lack of prominence of mental health in the health system (Saraceno et al., 2007; Saxena et al., 2007). At the community level, the attempts to address the treatment gap are thwarted by stigma and cultural beliefs attached to mental illness (Alie & Agyapong, 2015; Patel et al., 2011).

The improved delivery of MHC services in LMICs is essential to counter not only the suffering and morbidity of MNS disorders, but also to decrease the stigma and discrimination that sufferers of MNS disorders and their families experience, the economic costs, and the mortality linked to these illnesses (Patel et al., 2016).

2.2.4.2 Recent advances in mental health care

Considerable effort is being made to scale-up MHC in LMICs (Faregh et al., 2019). These efforts include a number of publications and innovations in relation to global mental health. These endeavours focus on the establishment of a knowledge and evidence base to test and illustrate the effectiveness of mental interventions that will narrow the treatment gap, especially in LMICs (Davies & Lund, 2017; Semrau et al., 2015). The publications and innovations to promote mental health include the Lancet series on global mental health in 2007and 2011, the WHO's Mental Health Gap Action Programme (mhGAP) (WHO, 2010), the WHO resolution in 2012 and action plan in 2013 (WHO, 2013) in which the primary objectives insist on a health systems approach (Semrau et al., 2015), the National Institute of Mental Health's (NIMH) establishment of Collaborative Hubs for International Research in Mental Health, and a review of Grand Challenges in Global Mental Health (Collins et al., 2011).

One such innovation was the Mental Health Gap Action Programme-Intervention Guide (mhGAP-IG), a manual first published in 2010, and then as the mhGAP-IG 2.0 manual in 2016. The intervention manuals provide guidelines and strategies for the training and implementation of non-specialised health workers

(NSHWs) engaged in task-shifting. As a clinical tool, the focus is the assessment and treatment of certain priority mental disorders such as alcohol use disorders, depression, schizophrenia, bipolar disorders, epilepsy and suicide. Recommended training time for NSHWs is a week, and includes an educational component as well as relevant videos, group work and role-play (Faregh et al., 2019).

The WHO, in its response to the need to scale-up mental health services in LMICs, developed the Mental Health Gap Action Programme (mhGAP) set of tools, which include the Mental Health Gap Action Programme – Intervention Guide (mhGAP-IG) and the Mental Health Gap Action Programme-Humanitarian Intervention Guide (mhGAP-HIG), to enhance primary mental health care by using task-shifting as a strategy (Faregh et al., 2019). Task-shifting is the redistribution of certain tasks from health care specialists to NSHWs who have less training and fewer qualifications (Dos Santos et al., 2016; Nyatsanza et al., 2016).The mhGAP set of tools are specifically meant for employment by NSHWs from various backgrounds, and are available for free in nine different languages (WHO, 2015). Trained NSHWs could include nurses, physicians, mid-wives, health technicians, community health workers (CHWs), and, rarely, traditional healers (Faregh et al., 2019). To date, the mhGAP tools have been used in over 100 countries (Keynejad et al., 2018), with some initiatives engaging full packages, while others select only certain modules. The training material is adaptable to different contexts and settings (Faregh et al., 2019).

A number of initiatives, such as the Programme for Improving Mental health care (PRIME), and emerging mental health systems in LMICs (EMERALD) have assessed and reported on the adaptation, implementation and evaluation of mhGAP-IG in LMICs (Faregh et al., 2019). PRIME, a group of research institutions that work with Ministries of Health in five countries (Ethiopia, India, Nepal, South Africa and Uganda) aims to publish excellent research on treatment for priority mental disorders in under-resourced settings by adapting, implementing and evaluating the mhGAP-IG (WHO, 2010). A commentary (Davies & Lund, 2017) reported on case studies of both PRIME and Africa Focus on Intervention Research for Mental health (AFFIRM). AFFIRM is a research hub that focuses on task-shifting of mental health care in LMICs in Africa. The focus of the case studies were interventions aimed at reducing the treatment gap by promoting the integration of mental health into primary health care systems through task-shifting. At the time of the commentary, PRIME worked

with stakeholders of the district sites in the five countries to develop culturally- and site appropriate mental health care plans (MHCP) based on the mhGAP-IG. The relevance, appropriateness, cost and effect of the MHCPs were tested. The barriers that PRIME encountered in the implementation of task-shifting treatment included a lack of mental health care specialists to supervise non-specialist health care workers, inadequate financial resources, stigma, insufficient information about treatment along with a lack of community awareness.

AFFIRM conducted Randomised Controlled Trials (RCTs) in two countries, Ethiopia and South Africa. In Ethiopia, the aim of the RCT was to ascertain how cost-effective task-shifted care by non-specialised health workers would be for severe mental disorders when compared with specialist health care in the country. In South Africa, the objective of the RCT was to establish how cost-effective task-shifted care by non-specialised health workers for maternal depression would be when compared with usual care.

Although the results of these two innovations were not available at the time of the commentary, experiences from both PRIME and AFFIRM afforded practitioners, researchers and policy makers a number of valuable lessons with regards to the integration of mental health into primary health care systems. Stakeholders were encouraged to work collaboratively with local partners, use primary health care centres, employ local cultural notions of distress and relevant scenarios to elicit symptoms, use manuals to guide interventions by NSHWs, provide regular supervision and support, remunerate NSHWs, strengthen primary care mental health systems, and engage problems or resolutions identified by governments who were open for change.

EMERALD, the initiative that focused on health system strengthening in six LMICs (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda), ran from 2012 to 2017. EMERALD was linked to PRIME, in that PRIME was centered on mental health service enhancement at district, facility and community levels, EMERALD focused on the strengthening of mental health systems to support these services, especially at national, regional and district levels (Semrau et al., 2015). Barriers to the strengthening of health systems that EMERALD uncovered included stigma and discrimination, poor user and carer involvement, inadequate circulation of relevant research (Semrau et al., 2015) and poor governance (Petersen et al., 2019).

The manuals of the mhGAP-IG have been modified for use in humanitarian and refugee crisis situations in the Mental Health Gap Action Programme-Humanitarian Intervention Guide (mhGAP-HIG). Certain components have been removed, and others replaced with information relating to humanitarian crises, in particular, topics relating to posttraumatic stress disorder (PTSD), acute stress, and bereavement. The WHO is committed to updating guidelines every two years, and new material every five years. (Faregh et al., 2019).

2.2.4.3 Task-shifting (also known as task-sharing)

A crucial strategy, outlined in publications and demonstrated via different initiatives, is the integration of MHC into PHC systems in LMICs (Petersen et al., 2017) using task-shifting, also known as task-sharing, as promoted by the WHO's global mental health action plan (WHO, 2013b). This strategy of skill sharing with support from specialists (Davies & Lund, 2017) has become a means to resolve the shortage of health care specialists, and improve the delivery of health care by increasing the number of NSHWs (Faregh et al., 2019). A recent study on task-shifting in LMICs (Petersen et al., 2019) reported the findings from the EMERALD research group on barriers, facilitators and results of attempts to scale up MHC into PHC level at six LMICs sites in Sub-Saharan Africa and South East Asia (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda). The primary medium for the integration was task-sharing with the training of PHC workers in the mhGAP-IG or context-driven versions of it. The study employed a cross-sectional research design and researchers conducted semi-structured qualitative interviews with significant stakeholders at all the sites. The stakeholders included provincial, district and facility managers and service providers. The Consolidated Framework for Implementation Research (CFIR), as well as, the WHO health system building blocks were used to guide the analysis. Findings with regards to the barriers on various sites included poor intersectoral collaboration in health systems, a lack of a specific budget for mental health, ineffective mental health information systems and a lack of specialist human resources for mental health. The facilitators on different sites included the operational referral system between PHC and other levels of care, the engaging of community health workers (CHW), guidelines for the integration of chronic care, and a functioning medication dispensing system between different sectors. The limitations of the study were the exclusion of certain parties such as care users, their families and care-givers, and service providers who were not part of the ministries of

health in the different countries. Furthermore, some content of the interviews could have been lost during translation which was necessary for standardization.

Further facilitators related to task-shifting were reported by other studies. These studies revealed that the provision of MHC by NSHWs was affordable, and had been implemented for depression (Patel, 2010), perinatal psychiatric disorders (Rahmen et al., 2013), and psychosis (Chatterjee et al., 2014). Furthermore, these health care workers were often members of the local communities, and, therefore, had valuable insight into and understanding of the socio-cultural context (Kakuma et al., 2011).

The training of NSHWs for task-shifting is, however, not sufficient (Petersen et al., 2019; Thornicroft et al., 2016). Petersen et al. (2019) reported that, although the integration of MHC into PHC level using task-shifting was beneficial, research also revealed that NSHWs, which included primary health workers such as nurses, as well as community health workers, engaged in task-shifting, reported several barriers to their provision of MHC. Some NSHWs, responding to the stigma and discrimination attached to mental illness, eschewed patients with mental health conditions, even after they had been trained. Others regarded integrated MHC as an extra unwelcome burden to their routine work, and added that there was a lack of specialist supervision and support. Furthermore, indications were that NSHWs easily could become overburdened given the high burdens of disease (Petersen et al., 2019).

PMHC is needed in underserved communities, and the studies cited show that task-shifting has been used to fill this gap. However, task-shifting refers to training people who are not involved in MHC and upskilling them to perform this role. In South Africa, we have mental health professionals who are actually trained to provide PMHC, i.e., registered counsellors.

2.3 Registered counsellors in South Africa

2.3.1 Background: Primary mental health care in South Africa

In South Africa, a middle-income country, the burden of mental illness is exacerbated by significant socioeconomic factors such as poverty and unemployment (De Kock & Pillay, 2016), as well as by chronic communicable diseases such as HIV/AIDS and non-communicable diseases (NCDs) such as diabetes, all of which contribute to the increasing burden of mental illness in the country (Myers et al., 2018). According to the Global Burden of Disease (2016),

mental and substance use disorders have become the primary cause of Years Lost due to Disability (YLD) in South Africa (Docrat et al., 2019).

The health system in South Africa is made up of a public sector that provides health care for 80% - 85% of South Africans, and a smaller private sector that takes care of an affluent minority. The state contributes only 48% to the total health budget, with the private sector making up the balance. However, as 80% - 85% of South Africans depend on the state for their health care, the public health sector is under great strain, and it struggles to sustain long-term chronic care, increase the capacity of acute care, and manage an under-resourced health workforce and unpredictable medicine supply (Health Project Policy SA, 2016). The limited resources that are available are still mainly pooled at psychiatric hospitals that treat severe mental disorders, and do so via a disease-focused rather than an integrated model of care (Schneider et al., 2016).

After the now famous paper which heralded “No health without mental health” (Prince et al., 2007), the Lancet Commission on Global Mental Health and Sustainable Development (2018) reiterated that mental health and the treatment of mental illness were critical priorities in establishing equity in access to health services. This manifested as an increase of UHC and the highlighting of the importance of providing context-driven and inclusive PMHC, as well the understanding that mental health is at the heart of sustainable development (Docrat et al., 2019). The South African government, in support of these sentiments, initiated the National Health Insurance (NHI) plan in 2011, with the intent of providing UHC for all South Africans. The NHI is meant to be fully rolled out by 2025, and will be financed by taxes, surcharges on taxable income and potentially increased Value Added Tax (VAT) (NDOH, 2017). The launching of the South African National Mental Health Framework and Strategic Plan 2013-2020 (MHFP) in 2013 also reflected a commitment to greater equitable access to integrated MHC, focusing, in particular, on the full integration of MHC into PHC (Docrat et al., 2019). Schneider et al. (2016) reported, however, that if South African mental health priorities are ignored by policy and actions that facilitate the roll out of the NHI, mental health will continue to be neglected, and the MHPF will be challenging to implement. Such developments would jeopardize the integration of MHC into PHC in the country. To date, research indicates that South Africa, in global terms, has been a forerunner of integrating MHC into PHC, but there is still a great deal of work to be done. According to Docrat

et al. (2019), the implementation of the MHFP remains incomplete, and there are no budgets committed to its implementation. Forty-three years after the Alma Ata Primary Health Care conference in 1978, equitable and accessible MHC for all South Africans is still not the norm (De Kock & Pillay, 2016).

Several studies have been conducted on the lack of resources to resolve the treatment gap in South Africa. These studies include research on sustainable financial plans of action for MHC (Docrat et al., 2019), task-shared mental health interventions by NSHWs (Myers et al., 2018; Myers et al., 2019; Nyatsanza et al., 2016; Petersen et al., 2011; Selohilwe et al., 2019), the scarcity of mental health specialists in the public sector (De Kock & Pillay, 2017; Petersen et al., 2009), the overburdening of PHC workers and inept use of available resources (Petersen et al., 2007), and the lack of human resources to deal with the mental health conditions of the population (Elkonin & Sandison, 2006; 2010; Rouillard et al., 2016).

The decentralisation of health care, and the integration of MHC in PHC, elements of the restructuring of the health care system in South Africa, are strategies that have been implemented to facilitate accessible and affordable MHC for South Africans (Petersen et al., 2010). Task-shifting has also been engaged in this restructuring process to combat the lack of health care workers in the country (Spedding 2017 cited in Fisher, 2017). In South Africa, as in other LMICs, mental health nurses (MHNs) (De Kock & Pillay, 2016), community health workers, village health workers and HIV counsellors are among the NSHWs that have been deployed in task-shifting (Davies & Lund, 2017). However, not many studies reported effective evidence-based task-shifted interventions and the relevant skills to provide the required psychological assistance for people with severe mental health conditions in South Africa (Petersen et al., 2010; Spedding 2017 cited in Fisher, 2017). It has also been reported that NSHWs who are or could be trained to provide MHC are already over-burdened (Davies & Lund, 2017; Seidman & Atun, 2017) or often do not want to be part of this endeavour (Petersen, 2004). Furthermore, task shifting is not a comprehensive remedy for an ailing health system. Without proper management and supervision, non-specialist mental health care workers engaged in task shifting could raise system costs or hamper the efficiency of the health system if they are employed at facilities but do not enhance the help-seeking behaviour of patients or demonstrate inadequate clinical training. This could undermine population health outcomes (Seidman & Atun, 2017). Petersen et al. (2012) suggested that registered

counsellors (RCs), mental health counsellors with a 4-year Bachelor of Psychology (BPsych) degree could be employed to provide mental health care at primary care level as they had been specifically trained to provide this service. The RCs would not only train, supervise and support non-specialised mental health workers, they would also provide counselling services, screen and refer patients appropriately.

2.3.2 Registered counsellors

Limited research has been done on RCs in South Africa (Rouillard et al., 2016). The research that has been published focused on the state of affairs of RCs (Abel & Louw, 2009), registration and employment (Elkonin & Sandison, 2006; Kotze & Carolissen, 2005), and the training and professional role of RCs (Elkonin & Sandison, 2010; Fisher, 2017; Rouillard et al., 2016).

2.3.2.1 Registered counsellors' scope of practice

With the overburdening of PHC nurses and the limited ability of NSHWs, the need for the RC category was identified for primary level care at district level in the health system in South Africa (Petersen, 2004). The RC category was conceptualised as a mid-level mental health worker who would increase human resource capacity for the mental health needs of communities (Department of Health, 2005 cited in Fisher, 2017). The category was created and launched in 2003 (Abel & Louw, 2009; Elkonin & Sandison, 2006). The particular purpose of the RC category was the provision of primary psychological services in diverse communities to improve the well-being of those communities. These psychological services, rendered at PHC level, included basic counselling services, the prevention of mental illness, and the promotion of psycho-social health in communities (HPCSA, 2013; 2019). The scope of practice of the RC is limited when compared to the services that psychologists render (Abel & Louw, 2009). The scope of practice of the clinical psychologist, for example, includes providing bio-psycho-social MHC across a lifetime, assessment, diagnosis and treatment of mild to severe and complex psychological problems and disorders (HPCSA 2018). The counselling psychologist's scope of practice includes the promotion of the well-being of individuals, families, groups and communities, and the assessment, diagnosis and treatment of clients who are dealing with life challenges such as psychological crises, trauma, bereavement, and maladjustment (HPCSA 2018).

Nonetheless, the RC category required a four-year training in Psychology, as well as a six-month practicum / internship. The qualified RC would be registered with

the Health Professions Council of South Africa (HPCSA), and by 2019, would be able to render primary psychological services in various community contexts. These included South African Police Service (SAPS), South African Defence Force (SANDF), Correctional Services, the Department of Labour, Primary Health Care centres, Mortuary Services, district hospitals, schools, student counselling centres, Early Child Development centres, NGOs, non-profit organizations (NPOs), Technical Vocational Education and Training (TVET) colleges, Employee Assistance Programmes (EAP), and hospices (HPCSA, 2019).

2.3.2.2 The training and professional role of RCs in South Africa

A doctoral study (Fisher, 2017) explored the training of RCs, as well as their professional identity construction and the current status of this mental health professional. Fisher (2017) explained that professional identity construction was a continuous and evolving process as professional identity was socially constructed and restructured. The individual is impacted by the social influence of the context in which they are ensconced. Fisher (2017) investigated the current status of RCs by ascertaining their demographic status, their experience of training, their professional activities, their relationship with the HPCSA, and their professional identity. A multi-method research design consisting of a questionnaire and qualitative interviews was used to collect data. The questionnaire was employed to explore the realities and challenges for the training of RCs, as well as the current status of the RC. The quantitative data were collected with an interactive computerised self-administered survey using Survey Monkey. 687 participants completed the questionnaires. Qualitative interviews, which were 25 to 40 minutes long, were used to explore the professional identity construction of 26 of these participants. These interviews were conducted using a semi-structured interview schedule and pertinent prompts. The interviews were done mainly via Skype, or by telephone if the participant did not have access to Skype.

The quantitative results relating to the demographic profile of the RC category in terms of size, gender, ethnicity and geographical distribution revealed disquieting information. Fisher (2017) reports that, according to a HPCSA national survey (HPCSA, 2017b), the Bachelor of Psychology (RC) degree training of RCs peaked between 2000 – 2009, but then, by 2017, there was a decline in numbers. The Bachelor of Psychology Equivalent degree training reflected the same trend, with an acute decrease in students enrolling for this degree. At the time of the study, there

were 1979 RCs trained and registered with the HPCSA, and they were to service 54 956 900 people in South Africa (HPCSA, 2016c; Stats SA, 2016). It was clear that based on the disproportionate number of RCs in relation to the population, the RC category had not scaled up PMHC service, counselling and community interventions. Furthermore, Black and White participants made up the bulk of the sample with 29,4% and 51% respectively. This ratio was disproportionate to the racial distribution of South Africa which has a Black majority of 80,50% (Fisher, 2017). The results also revealed that most RCs were based in urban areas, particularly in Gauteng (33,3%) and in the Western Cape (28,4%). This indicated that RCs were not providing PMHC to rural communities, where 40% of the SA population resides (De Kock & Pillay, 2016), and who are most in need of their services. With the majority of RCs working in urban environments, they gravitated towards private practice and, according to Fisher (2017), spent almost 90% of the work week providing individual counselling. Several other studies also reported these trends (Abel & Louw, 2009; Elkonin & Sandison, 2006; 2010; Kotze & Carolissen, 2005; Rouillard et al., 2016). With this style of practice, the intention of the RC category to provide community-based psychological interventions and the promotion of MHC for individuals and groups in diverse and under-resourced areas remains unrealised (Fisher, 2017).

The qualitative interviews, used to explore the professional identity construction of the RC, reported five themes. These themes were 1) training towards a professional identity, 2) inner realization of future vocation in building a professional identity, 3) excitement for the impact of working as a professional, 4) environmental activators vs. inhibitors of professional identity construction, and 5) finding fulfilment in the ongoing construction of professional identity.

Findings related to the first theme, the training of RCs towards professional identity, are pertinent to my study as my study will also interrogate this aspect of the RC category. Findings revealed that 25% of RCs believed they were being specifically trained to provide much needed PMHC in South Africa. These participants across the study agreed that RCs were suitably qualified and trained to engage in the much-needed promotion of mental health and the administering of preventative MHC in communities across South Africa. This included basic counselling, psycho-education, psycho-social support and guidance, the designing and presentation of programmes to promote mental health, trauma debriefing and

skills development. And these RCs were keen to provide this kind of psychological service to the South African population.

An overarching and cardinal finding related to the recognition of the importance of training RCs was that the category of RC was well aligned with government's intention to provide greater accessibility to psychological services, and RCs are able to fill this services gap. The study also found, however, that there was apprehension about the viability of providing Bachelor of Psychology (RC) training as there were few jobs and posts available for RCs. Furthermore, the institutions struggled to understand HPCSA requirements, often contradictory and ambiguous, for training RCs, and the training programmes themselves required significant resources with little financial return. The institutions which were confident that they could provide Bachelor of Psychology (RC) training were clear that they provided relevant and adequate practicum and supervision; their curricula focused on the competencies that were in line with the RC scope of practice, and their students were exposed to a wide range of psychological theories.

The findings of Fisher (2017) support those of Elkonin and Sandison (2010) who found that RC trainees in their various placements had more than sufficiently mastered the core competencies as prescribed by the Professional Board of Psychology. This competency lends credibility to the category (Elkonin & Sandison, 2010). Elkonin and Sandison (2010) employed a qualitative approach to explore the perceptions and experiences of 15 supervisors and managers regarding the efficacy of RCs and RC trainees in their different placements. A semi-structured interview questionnaire was administered by telephone or during face-to-face interviews. The findings indicated that the RC and RC trainee were highly valued in a number of different settings. They were efficient, dependable and essential. Their training indicated that they had acquired the appropriate skills, and that the RCs and RC trainees were familiar with their levels of competency.

2.3.2.3 Lack of employment opportunities

Findings in Fisher (2017) furthermore reported that, along with a lack of recognition of RCs in public and professional domains, a lack of belonging within the profession of psychology, a sense of professional inferiority, and difficulties with the HPCSA, there was a substantial lack of employment opportunities for RCs. The study found that, although RCs had been trained to work in the public sector, no positions had been created for them. Participants relegated this to the stance that

there were no state grants or government funding for RCs. RCs that were employed earned sub-optimal salaries in under-resourced communities where low salaries were inevitable. Many then had to engage concurrent employment to supplement their income. Several previous studies also reported this development (Abel & Louw, 2009; Elkonin & Sandison, 2006; 2010; Rouillard et al., 2016). Fisher (2017) also found that RCs resorted to volunteering in communities, or had been forced into private practice. Many left the profession entirely. The study found that just less than half (47,2%; n=264) indicated that they would select another career with the knowledge they now had of being a RC. Elkonin and Sandison found that very few Bachelor of Psychology graduates registered with the Professional Board of Psychology (14,3%; n=12/84) between 2002 and 2004, and that most of these graduates had applied for and been accepted into further postgraduate studies, or had opted for alternate careers.

According to Fisher (2017), and, on a more positive note, the study found that more than half of the participants (54%; n=307/571) would still have chosen to train and work as RCs. These participants related that they were keen to work in under-resourced and disenfranchised communities. They were motived to provide supportive counselling and community based mental health promotion and care to those in need.

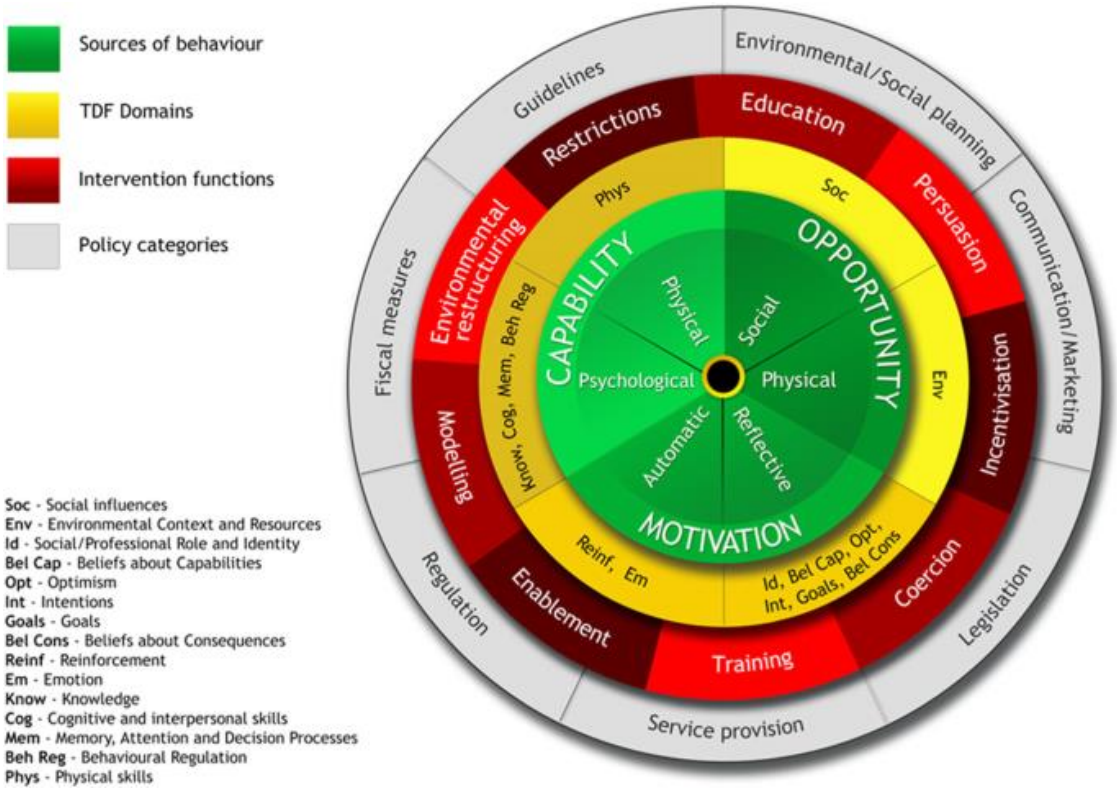
The discussion in Chapter 2 engaged current literature on primary mental health care in LMICs, in particular the barriers and facilitators to the delivery of primary mental health in these countries, and the health workers involved in this service provision. In this final part of the chapter, I discuss the theoretical framework that I employed to frame my study.

2.4 Theoretical Framework

In my study, I explored the perceived barriers and facilitators to the delivery of PMHC in diverse and under-resourced communities by RCs in private practice. I drew on the Capability, Opportunity, Motivation model (COM-B model) at the heart of the Behaviour Change Wheel (BCW) and the Theoretical Domains Framework (TDF) (see Figure 1) to understand the barriers and facilitators that participants of the study described.

Figure 1

The Behaviour Change Wheel (BCW) and the Theoretical Domains Framework (TDF) (Michie et al., 2014)



I employed these two frameworks as they can be employed to identify the barriers and facilitators to behaviour change, and the identified barriers and facilitators can, in turn, be used to design and implement appropriate interventions to facilitate change (Smith et al., 2019). Limitations of other models of behaviour, such as the Theory of Planned Behaviour and the Health Belief Model, are that they only assist in the understanding or prediction of behaviour (Kok et al., 2004, as cited in Ojo et al., 2019), do not comprehend behaviour change, or facilitate the development of relevant interventions (Brug et al., 2004, as cited in Ojo et al., 2019).

The COM-B model and TDF have been used to understand health behaviours such as hearing healthcare (Van Leeuwen et al., 2018), smoking cessation in MHC settings (Smith et al., 2019), self-care of minor ailments (MA) (Richardson et al., 2019), and the prevention of melioidosis (Suntornsut et al., 2016).

The COM-B model is the result of the integration of concepts from 19 behaviour change frameworks that were identified by Michie and her colleagues (2011). The COM-B model, at the centre of the BCW, is comprised of three components which interact and determine behaviour(B), which, in turn, influences the components. The components are Capability (C), Opportunity (O) and Motivation (M) (Michie et al., 2011). The model purports that for a particular behaviour, also known as the target behaviour, to be demonstrated, the individual must have the capability and the opportunity to perform the behaviour, and be motivated to do so (Van Leeuwen et al., 2018).

The three components have two sub-components each. The two sub-components of capability are the physical capability and the psychological capability of the individual to perform a required activity (McDonagh et al., 2018). Physical capability includes relevant training, knowledge and skills of the individual, and psychological capability alludes to the ability to engage in necessary thought processes such as comprehension, reasoning and awareness. Opportunity indicates all the factors that reside outside of the individual that encourage or facilitate behaviour. Its two sub-components are social opportunity and physical opportunity. Social opportunity refers to the cultural milieu of the individual, which includes social factors and societal influences. Physical opportunity refers to opportunities afforded the individual by the environmental context and resources (McDonagh et al., 2018). Motivation references all the brain processes that stimulate and determine behaviour. Its sub-components are reflective motivation and automatic motivation. Reflective motivation includes goals, decision-making processes, beliefs and identity. Automatic motivation refers to habitual processes which include emotions and impulses (Alexander et al., 2014; McDonagh et al., 2018). C and O can influence M, and a particular behaviour can impact C, O and M (Michie et al., 2011).

The COM-B model insists on the equal importance of intra-psychic and external factors in determining behaviour, and its inclusion of context is one of its strengths. In the COM-B model, the opportunity component is the context, indicating that behaviour must be understood in relation to context. The COM-B model, therefore, hinges on a thorough analysis of behaviour and its starting point is the engaging of intra-psychic conditions in the individual and the social and environmental conditions that need to be present for a particular behaviour to be achieved (Michie et al., 2011).

The TDF is a theoretical framework, and is the synthesis of 33 behaviour and behaviour change theories that were grouped into 14 domains. The 14 domains of the TDF are the following (1) skills, (2) knowledge, (3) memory, attention and decision processes, (4) behavioural regulation, (5) social influences, (6) environmental context and resources, (7) social/professional role and identity, (8) beliefs about capabilities, (9) optimism, (10) intentions, (11) goals, (12) beliefs about consequences, (13) reinforcement, (14) emotion (Atkins et al., 2017; Richardson et al., 2019). The 14 domains can be linked to the COM-B model (see Table 1) (Michie et al., 2014), and, in so doing, provide a more detailed interrogation and understanding of behaviour (Atkins et al., 2017). The more granular the understanding of behaviour is, the more specific the identification of barriers and facilitators to the target behaviour can be (Atkins et al., 2017). As a theoretical framework, the TDF provides a lens through which to view and understand the cognitive, emotive, social and contextual influences on behaviour. While the 14 domains of the TDF include social and physical environment, most of the domains pertain to the capability and motivation of the individual (Atkins et al., 2019).

Table 1

The Three Components of the COM-B Model and the Fourteen Domains of the TDF

COM-B model		TDF
CAPABILITY	Physical	Skills
	Psychological	Knowledge Memory, Attention and Decision processes Behavioural Regulation
OPPORTUNITY	Social	Social influences
	Physical	Environmental context and resources
MOTIVATION	Reflective	Social/Professional role and identity Beliefs about capabilities Optimism Intentions Goals Belief about consequences
	Automatic	Reinforcement Emotion

While the COM-B model and the TDF are models of behaviour, they also assist with the design of interventions and the selection of policy categories that

target behaviour change. To design appropriate interventions, it is necessary to decide what the target behaviour is, and what components or combinations of components of the COM-B model would need to be adjusted to achieve the required behaviour.

The broadness of the COM-B model and the TDF has been criticized for not being particular enough (Jennings et al., 2019). The broadness of these models has been criticized because, by integrating different approaches to understanding behaviour and behaviour change, it is possible that more complex theories have been over-simplified (Ogden, 2016). Jennings et al. (2019), however, regarded this as a strength when employed at a population intervention level. As in my study, the heterogeneity of the sample population (various ages, gender, ethnicity) made it difficult to employ a single model that depended on particular processes in a specific domain (Jennings et al., 2019) By employing the comprehensive models, the distinct needs of a population could be ascertained, what needed to change could then be identified, and a relevant number of action plans could emanate from the analysis of behaviour

I use the BCW and the TDF to understand RCs' behaviour and practice around the delivery of PMHC to communities in South Africa. Specifically, the aim of the study is to identify and explore perceived barriers and facilitators that RCs in private practice experience in providing PMHC to diverse and under-resourced communities.

2.5 Conclusion

In this chapter, I reviewed literature that pertained to PMHC in LMICs, including South Africa. The focus was on the barriers and facilitators to the delivery of PMHC, and the human resources tasked with this service, in particular, the RC in South Africa. I concluded the chapter with a description of the two theoretical frameworks that I employed to frame and understand the study.

Chapter 3
Methodology

3.1 Introduction

In this chapter I describe the methodology that I used to conduct my research. Methodology, which comprises a number of logical steps to answer a research question, helps to understand not only the final outcome of the study, but also the process itself (Sridhar, 2008). This chapter includes a description of the research design and study setting, the characteristics and recruitment of the participants, and the data collection process and data analysis. I conclude the chapter with reflections on the trustworthiness of the findings, the credibility of the study, reflexivity, and ethical considerations of the study.

3.2 Research design

The aim of my study was to explore the current practices of registered counsellors (RCs) in private practice in South Africa, more specifically, what the barriers and facilitators were that they experienced when they provided primary mental health care (PMHC) to diverse communities in the country. Exploratory research facilitates the uncovering of new insights into a particular circumstance (Babbie & Mouton, 2002). In this study, I explored whether RCs were able to provide PMHC from their private practices and not, as was originally intended, from within the public sector. I used a cross-sectional study design as I collected and analysed data from a number of individuals at a particular point in time, selecting them on specific inclusion and exclusion criteria (Creswell, 2007; Setia, 2016).

I used semi-structured individual interviews, and employed a qualitative research approach in my data gathering. Qualitative research is employed to understand experiences, meaning and perspectives of participants (Hammarberg et al., 2015), and elicits rich and nuanced descriptions of experiences and perspectives of, among others, healthcare practitioners (Braun & Clark, 2014).

3.3 Study setting

This study was conducted among RCs living and working in South Africa. Most of these mental health practitioners lived and worked in urban settings of Gauteng and the Western Cape. All the participants were either in full-time or in part-time private practice, appropriately and adequately qualified, and registered with the Health Professionals Council South Africa (HPCSA). Most of the participants who were in part-time private practice were concurrently employed at schools.

3.4 Participants

Commensurate with the aim and objectives of the study, only RCs in private practice could participate in the study. Furthermore, the criteria for the selection of eligible participants included the following: participants had to be appropriately qualified and registered with the HPCSA, had at least one year of experience in private practice, and were available and willing to participate in the study. Eligible participants also had to be able to converse in English or Afrikaans as I am not proficient in other languages such as isiXhosa and isiZulu.

3.5 Participant recruitment

I used purposive and snowball sampling to recruit participants. Purposive sampling is a method that is commonly used in qualitative research (Palinkas et al., 2015). In this study, purposive sampling facilitated access to a well-defined sample, and provided information-rich data as the selected participants were knowledgeable about and had experience of a particular phenomenon (Etikan et al., 2016).

I started recruiting participants as soon as I obtained ethical approval for the proposed study. Via email, I requested permission from the Association for Registered Counsellors in South Africa (ARCSA) (see Appendix A) and from the Psychological Society of South Africa (PsySSA RC division) (see Appendix B) to access RCs listed at their respective organizations. ARCSA agreed to my posting an electronic invitation flyer on their social media platform, namely their WhatsApp Support Group. PsySSA sent the electronic invitation flyer to their RC members, and posted it on their social media platforms of Facebook and Instagram. Both organizations agreed to the promotion of the study once a month for three months. The electronic invitation flyer briefly described the purpose of the study, listed the inclusion and exclusion criteria, and included my email address. After two months, I had not recruited the intended 20 participants, and so engaged snowball sampling. This recruitment process was approved by the ethics committee. Snowball sampling meant that I requested participants whom I had recruited and interviewed to assist me by directly asking other RCs in private practice, who met the necessary criteria and could contribute to the study, to participate.

Potential participants responded to the electronic invitation to participate by emailing me. In the emails, they indicated that they were available and willing to participate. I replied via email, thanking the potential participants for their willingness to engage, and attached the participation information leaflet and consent form to this

email. In the information leaflet, I included a more detailed outline of the study and the participation process. I conveyed how the interviews would be conducted, that there were minimal risks or discomfort for participants, the rights, responsibilities and benefits of the participants, the confidentiality of the process, my contact details, and the contact details of my supervisors. I requested that the potential participants read the information leaflet, and then, if they were in agreement and willing to participate, complete, sign and return the attached consent form. I asked for the consent form (see Appendix C) to be signed and returned to me via email before the commencement of the interviews. At the end of three months, I had recruited and interviewed 19 participants.

3.6 Data collection

I conducted semi-structured qualitative interviews with the participants, and used an interview schedule to facilitate each interview. According to Babbie and Mouton (2011, as cited in Hofisi, 2014), a qualitative interview is an interaction between the interviewer, who has a general agenda of investigation rather than a particular list of questions that are posed in specific words in a specific order, and the interviewee. My interview schedule (see Appendix D), compiled in consultation with my supervisors, comprised of open-ended questions and relevant prompts that invited the participants to relate their real-life experiences of being in private practice, and their knowledge, skills, opportunities and motivation to provide PMHC in whichever words or order they chose to use. Furthermore, semi-structured qualitative interviews are often used in healthcare as this approach is flexible and, therefore, facilitates the uncovering of information that is significant to the participant but had not been thought of as important by the researcher (Gill et al., 2008).

The interviews were conducted from May to July 2020, and were between 45 and 60 minutes in duration (average length: 55 minutes). I conducted all the interviews via Skype from the safe and confidential space of my private consulting room. Online qualitative interviews have advantages (Weller, 2017). Among young people, this form of communication is common and familiar, and can facilitate disclosure. The remoteness and informality of this medium also ameliorates the pressure of the physical presence of the interviewer and the interview equipment and documents. This, in turn, facilitates easier participation for interviewees, with less risk of embarrassment and exposure. Access and convenience of participation from any location, and cost and time saving are further benefits. The rapport and richness of

online qualitative interviews is secured by the feeling of a salient and emotional connection that can be brought about by quality technology (Weller, 2017). The disadvantages of this form of communication include possible additional costs related to the required software or hardware, as well as potential technical difficulties during the preparation and conducting of the interviews, and during the uploading or accessing of the audio-recordings (Gray et al., 2020).

I began the interviews by introducing myself and reminding the participants of the nature of the research project. I then checked that they had signed and returned the consent form and thanked them for their willingness to participate. I explained the ethical considerations of the study, including their right to voluntary withdrawal at any point during the interview and that I would be audio-recording the interview. After eliciting demographic information from each participant, I continued with the open-ended questions. My intention during each interview was to establish a rapport with the participants and gain their confidence so that I could as far as possible guarantee credibility and worthiness. Participants could choose to be interviewed in English or Afrikaans. The majority (n=13) opted for English. At the end of the interviews, I thanked the participants for their contribution to the study. All the audio recordings were downloaded and stored on my personal password-protected computer.

3.7 Data analysis

I used thematic analysis to analyse the data. It has been postulated that sample sizes ranging from six to sixteen interviews achieve saturation within thematic analysis, although this does depend on the nature of the research and the required degree of saturation (Braun & Clarke, 2019). In this study, the analytic approach was necessarily thematic and related to data provided by interviews or focus groups, and, therefore, inductive thematic saturation was achieved once there were no new codes or themes reported in the data (Saunders et al., 2018). After I had transcribed thirteen interviews and my assistant two interviews, no new codes or themes were reported in the data. I allotted the 15 participants pseudonyms to protect their identity and ensure anonymity. Once the interviews were transcribed, I uploaded the transcriptions and audio-recordings to Atlas ti. 8, computer-assisted qualitative data analysis software, on my personal password-protected laptop. Atlas ti. 8 facilitates the management of and access to uploaded texts, audio-recordings, images and videos (Atlas ti. 8 Windows). My supervisors had access to all the data on this software programme. After I had uploaded the audio-recordings and

transcriptions to Atlas ti. 8, I sent my supervisors a password protected link to the data stored in Atlas ti. 8. They used this secure link to access the data. I kept a back-up of the transcriptions and audio-recordings in a safe place in my consulting room.

I employed thematic analysis to identify repeated patterns across the data. As a pattern-based method of analysis, thematic analysis focuses mainly on what people say, rather than how they do so (Braun et al., 2015). This was important in my study as my focus in the interviews was on what my participants related in response to my research aim and objectives. Another advantage of using thematic analysis is that it is flexible as it can be used within various frameworks to answer different kinds of research questions (Braun et al., 2015). I could, therefore, use it within the theoretical frameworks of my study, the Capability, Opportunity, Motivation (COM-B) model and the Theoretical Domains Framework (TDF). Braun and Clarke (2006) outlined the six phases of thematic analysis, emphasising that the analysis was not a linear process. The method is reiterative with continual revisiting of the different phases. The six phases of the thematic analysis process are 1) familiarisation with the data, 2) coding, 3) identifying themes, 4) reviewing the themes, 5) defining and naming themes, and 6) writing up the analysis (Braun & Clarke, 2006).

My familiarisation with the data was facilitated by my conducting all the interviews myself, and by my listening to and transcribing the majority of interviews. It was interesting that the two interviews that I did not personally transcribe were the most difficult to become familiar with. I had to reread these transcripts more often than the others. Although the transcribing was time-consuming, this process, together with my later repeated reading of the transcriptions, helped to immerse me in the data. I gradually identified perceptions and notions of the participants relevant to my research question in the data (Braun et al., 2015).

During the second phase, I continued working within the Atlas ti. 8 programme which collated my coded data. I systematically worked through the entire data set, reading each sentence of every transcription. As I read, I highlighted and tagged data items that were in any way pertinent to my study, and coded these. The codes were phrases that provided a concise description of important elements of the highlighted extracts of text. As the codes relayed the essence of the highlighted and tagged extracts of text and were largely descriptive, they made sense and circumvented having to refer to the data set all the time (Braun et al., 2015). During

the coding process, I focused on coding consistently which meant that I sometimes went back to the codes to edit or rename them, all the while keeping in mind the overall research aim of my study (Braun et al., 2015). I assigned more than one code to some of the extracts of texts that I had highlighted as the extract contained more than a single item of relevant information (Braun & Clarke, 2006). After I had coded the first transcription, my supervisors reviewed the coded transcription and provided the necessary feedback and guidance. After I had coded a further number of transcriptions, we followed the same procedure. In this way, there was constant supervision of this process.

Once I had a list of codes across the entire data set, I began searching for potential themes. Themes often reveal patterns at a more abstract level and cannot easily be identified without a thorough analysis (Braun & Clarke, 2019). Furthermore, according to Braun and Clark (2006), a theme encompasses something significant in relation to the overall research question and more broadly identifies a tier of meaning than a code does. This means that many different codes usually combine to form a theme. I searched my list of codes to determine which codes could be combined into potential themes. At this point, I engaged broad concepts embedded in my theoretical frameworks, in particular, the components of the COM-B model of behaviour, capability, opportunity and motivation, to guide me. My search for themes was, therefore, loosely guided by my theoretical interest in the research situation (Braun & Clark, 2006). I grouped the codes according to the capabilities, opportunities and motivation of participants' transcriptions, and codes that did not fit anywhere, I grouped as miscellaneous (Braun & Clarke, 2006). By the end of this phase, I had established a number of candidate themes (Braun et al., 2015) that reflected on components of the COM-B model.

During the next phase of the analysis, I refined my set of candidate themes. I reviewed the candidate themes by checking how many codes supported them, how they related to one another and to my research aim and objectives, and whether there were themes that could be amalgamated or discarded. I then used the components of the COM-B model to develop a thematic map of the themes. The map was arranged with a central concept, overarching themes that informed the central concept, and sub-themes that detailed specific aspects of the core concept (Braun et al., 2015).

Phase 5 prompted the reviewing and refining of the themes of my thematic map (Braun & Clarke, 2006). I identified three main themes which I had modelled on components of the COM-B model, and related sub-themes which detailed the main themes in a structured and more specific manner. I returned to the dataset to verify the sub-themes. I checked whether the data within the sub-themes captured the aspect of the data they represented, whether they were distinct but, simultaneously, supported the main themes meaningfully and coherently (Braun & Clarke, 2006). I rearranged the order of the main themes so that they would facilitate a logical narrative development of the write-up of the report. During the review and revision, I settled on the final names of the themes and sub-themes which would provide the reader with a succinct and clear idea of each one (Braun & Clarke, 2006). I then wrote up a full analysis of each theme in which I described the theme, how it related to the overall narrative of the data set and to my research question (Braun & Clarke, 2006). I searched the entire data set for relevant quotations for each theme, and included them in my overall narrative (Braun & Clarke, 2006). I included compelling quotations that informed my narrative analysis, using them analytically as the analysis referenced particular elements of the quotations (Braun et al., 2015).

Phase 6 is the final phase of the analysis, and comprises the write-up of the report (Braun & Clark, 2006). I combined my analysis with the selected quotations, and included current literature, to develop a report that responded to my research question in a logical and evidenced manner (Braun, Clark & Rance, 2015). My report made an argument in relation to the barriers that RCs in private practice encountered when they provided or attempted to provide PMHC to communities in South Africa.

3.8 Trustworthiness

Guba and Lincoln (1985, as cited in Nowell et al., 2017) defined trustworthiness of research findings and interpretation in terms of their credibility, transferability, dependability and confirmability. This definition has been widely accepted and engaged in research (Nowell et al., 2017). In my study, the lengthy and thorough engagement with the research process, the continual and consistent debriefing with my supervisors (Guba & Lincoln, 1985, as cited in Nowell et al., 2017), the employment of recognized research methods and the inclusion of relevant current literature to frame my study (Shenton, 2004) lent to the study's credibility. Furthermore, the preparation for interviewing, facilitated by my supervisors, as well as my experience as a RC in private practice for eight years, provided me with

appropriate interviewing skills. Although my research cannot be generalised, there is transferability that can be done as there are clear descriptions of the context of the research and thick descriptions elicited via the open-ended questions and prompts of the semi-structured interview schedule (Guba & Lincoln, 1985, as cited in Nowell et al., 2017), descriptions of the nature of participants, and a relevant phenomenon that was investigated (Shenton, 2004). I engaged with and documented the research process step-by-step. This included information about and from the participants, and the phenomenon under investigation, and used recognized theoretical frameworks to secure dependability of the study. Guba & Lincoln (1985, as cited in Nowell, 2017) postulated that the criterion of confirmability is established when credibility, transferability and dependability of the study have been confirmed.

3.9 Reflexivity

A late-comer to the profession of psychology, I have been a RC in private practice for eight years. I started my private practice in 2013, immediately after I had completed my academic training, written the board examination and registered with the Health Professions Council of South Africa (HPCSA). Like some of the participants that I interviewed in this study, I did not seek employment in the public sector as the option of private practice was attractive, independent and flexible. However, like most of the participants in my study, I had not been prepared for this kind of endeavour during my training, and was unaware of the many elements of running a private practice such as the legal requirement for professional indemnity insurance, registration with medical aids, and a counselling service agreement to protect myself and my practice. The exposure that I did have to community-based mental health care (MHC) provision, which was the original intention of the RC category, was during my internship when I worked at a government hospital in the Western Cape. Like many of the participants in my study, this was my first engagement with PMHC. My academic training had not prepared me for this kind of hands-on PMHC work, and this was also the experience of the majority of the participants of my study. Although the hospital where I worked was in a lower socio-economic environment, it was new, modern and well-staffed. This was reassuring and convenient for me as I, along with the other RC interns, were allotted specific rooms with sufficient equipment to provide supportive counselling and psycho-education. What overwhelmed and dismayed me at times, however, was my lack of training to engage and assist the clients from disenfranchised and poverty-stricken

communities with their commensurate mental health needs that stemmed from violence, abuse, neglect or marginalisation. Like with many of the participants in this study, it was the training by and support of professional staff at the non-governmental organization (NGO) that had provided me with the internship, that helped to develop some of the necessary hands-on skills for community work in disenfranchised communities. As difficult as that year was, it taught me the most that I knew about the huge need for PMHC. At the time that we as RC interns worked at the hospital, there were no positions for RCs, and there was only one government appointed clinical psychologist that served patients in need of MHC at the hospital. Simultaneously, this clinical psychologist also had to serve patients in need of MHC in the smaller surrounding towns and clinics. Clients that we referred waited weeks for an appointment with the psychologist.

Private practice, despite the administration and management that it required, was an easier space in terms of clients and their needs. Set up in an advantaged socio-economic neighbourhood, I provided mainly one-on-one supportive counselling and psycho-education to individuals and families who could afford my fees or had medical aids. As I focused on my private practice to provide a necessary and adequate income, I did not have the time to engage in community MHC projects or outreaches from my private practice. Unlike many of the participants in this study, I did not have to take on extra part-time employment alongside my private practice to make a living.

Research in the field of my own profession revealed personal blind spots and biases. I, for example, had been unaware of the original intention and focus of the RC category during my professional training and the running of my own private practice. My biases were elicited when I identified with the participants about the lack of recognition and engagement of RCs by government, other MH and health professionals and the public. I, with many of the participants, had to process feelings of indignation, marginalisation, inferiority and confusion at the lack of support from these sources. The lack of employment opportunities by government for a community-trained MH professional destined to work for government was perhaps the most frustrating and baffling discovery of the study. Biases elicited by the research were articulated and carefully managed during supervision sessions with my supervisors and in my research journal, and so did not cloud my academic engagement and articulation of the research topic.

During the interviews, I provided participants with a safe and confidential space, engaged them with open-ended questions and encouraged them to relate their lived experiences of being RCs. They responded in an honest and in-depth manner, and, often, the disillusionment and sense of abandonment that some of the participants relayed, had me rethink my own engagement with this profession.

3.10 Ethical considerations

This study was approved by the Research Ethics Committee at Stellenbosch University (approval number: 14630). Once I had ethical clearance, I started the recruitment of my participants. Before potential participants agreed to participate in the study, I informed them they could exit the study at any point without any negative consequences, that they did not have to respond to questions they did not want to answer, and that they could end the interview at any point. I also informed them that I foresaw minimal to no risks for them if they agreed to participate. I added that if they experienced any distress during the interview, we would discuss counselling or their contacting mental health help lines. I would provide them with the contact numbers of the Adcock Ingram Depression and Anxiety Helpline and the South African Depression and Anxiety Group (SADAG) which they could call.

I ensured that all participants signed the consent form before I conducted the interviews. The consent form conveyed the aim of the study, how I would conduct the research, and that only I and my supervisors would have access to the data. I checked that each participant understood the content of the consent form before they signed it. The signing of the consent form also confirmed the confidentiality of the process to the participants. The consent form confirmed that pseudonyms would be employed throughout the study to protect the identity of the participants, and that all data such as the interviews, the audio-recordings, transcriptions and data analysis would be stored on my password-protected laptop to further ensure confidentiality. It also conveyed that the recordings of the interviews, the transcriptions and data analysis would be accessed by only me and my supervisors. After five years, all the data would be carefully destroyed.

3.11 Summary

In this chapter, I described the research methodology that I employed in my study. I described the research design and setting, the participants, the data collection and analysis, the trustworthiness of the study, reflexivity and ethical considerations. The next chapter details the findings of my study.

Chapter 4
Findings

4.1 Introduction

In this chapter, I will relate my findings about the barriers and facilitators that registered counsellors (RCs) experienced in private practice in their delivery of primary mental health care (PMHC) to diverse and under-resourced communities. I begin by describing the demographic characteristics of the participants. I then describe the main themes of my findings which are (1) positive disposition among RCs to engage community, (2) the RC as an unacknowledged MH professional, and (3) limited alternatives to private practice.

4.1.1 Demographic characteristics of the participants

The participants in this study were 15 RCs who worked in private practice. Table 2 contains the demographic information of the participants. Ten participants were female and five were male. Participants' ages ranged from 25 to 67 years (average age = 41 years). Most of the participants resided in Gauteng (n=9), followed by the Western Cape (n=3). The majority of the participants were in full-time private practice (n=11), and all of the participants were registered with the HPCSA. All the participants had honours degrees, and the majority of participants either held master's degrees or were enrolled for a master's degree. One participant held a doctoral degree. Most of the participants had read their degrees at state universities (n=11), while the others read theirs at private tertiary institutions. Most of the interviews were conducted in English (n=13).

Table 2

Demographic Characteristics of the Participants

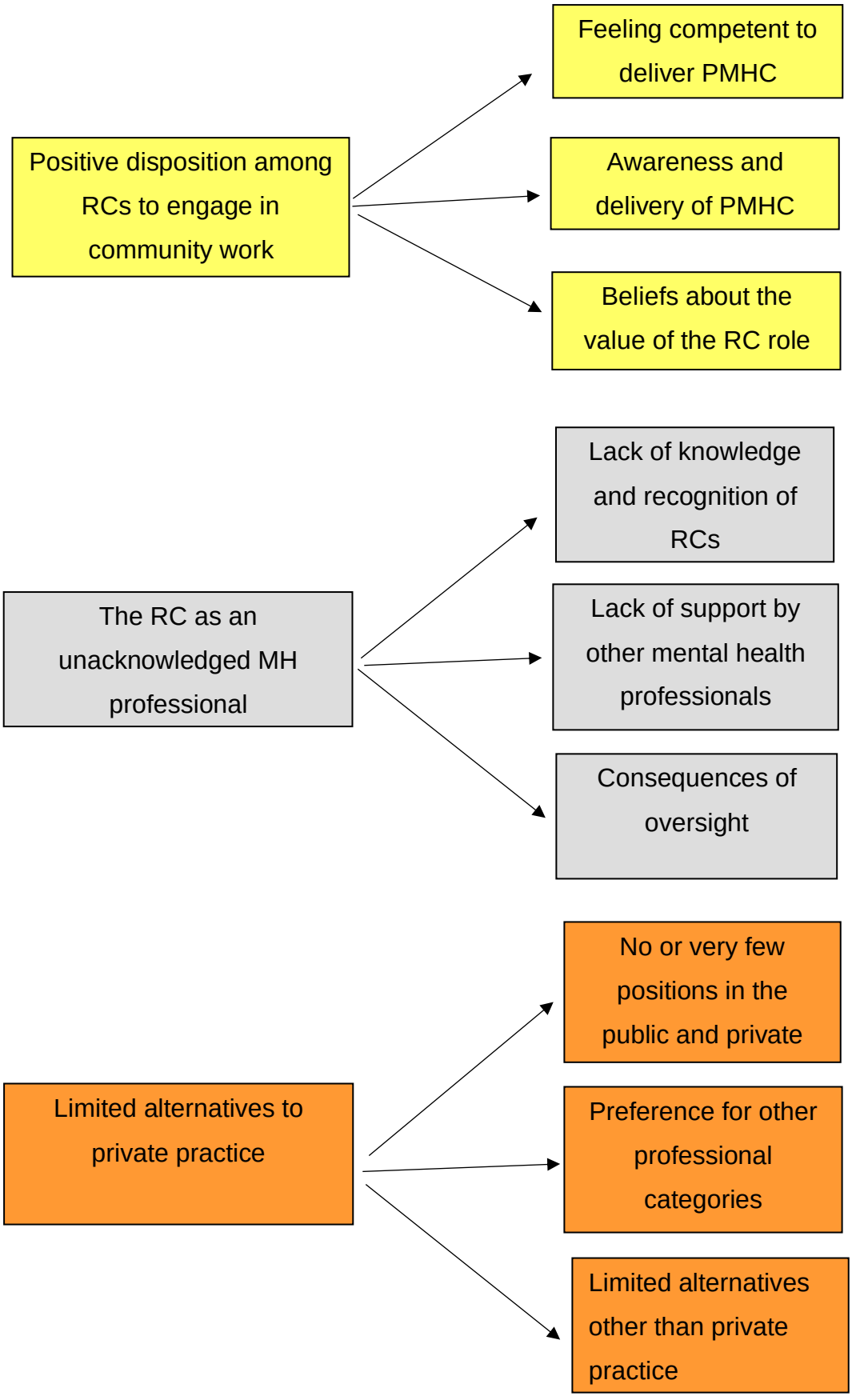
Description	***Number***
Age (years)	
Range	25 – 67
Mean	41
Relationship status	
Married	12
Divorced	1
Single	2
Qualifications	
Honours degrees	6
Master's degrees	4
Doctoral degree	1
Enrolled for master's degrees	4
Private practice	
Full-time	11
Part-time	4
Years registered with the HPCSA	
Range	2 -13
Mean	7,6 years

4.2 Description of the themes

My analysis of the interviews led to the identification of three main themes that describe the barriers and facilitators that RCs experienced when they provided PMHC to diverse communities. I named these themes (1) positive disposition among RCs to engage in communities, (2) the RC as an unacknowledged MH professional, and (3) limited alternatives to private practice (see Figure 2). Each theme consists of sub-themes, and I describe the themes and the sub-themes. I provide support for the themes and sub-themes by including quotations from the participants.

Figure 2

Visual Depiction of the Findings



4.2.1 Positive disposition among RCs to engage in community work

Most of the participants reported that they were keen to provide PMHC in diverse communities. I identified this positive disposition of the participants towards working in communities as a facilitator in the delivery of PMHC. I discuss this theme according to three sub-themes. The sub-themes are (1) feeling competent to deliver PMHC, (2) awareness and delivery of PMHC, and (3) beliefs about the value of the RC.

4.2.1.1 Feeling competent of deliver PMHC

All the participants reported feeling competent to deliver PMHC because they had the relevant knowledge and skills to do so. The majority of participants reported that the knowledge and skills that they acquired during their training prepared them to deliver PMHC competently, and identified their training as a facilitator in the delivery of PMHC. Participants attributed their competency to two aspects of their training. These two aspects were formal training and informal ongoing training including collegial networking.

Most participants stated that their formal training provided them with the prerequisite knowledge and skills to deliver PMHC. With regards to formal training, most participants differentiated between their academic training and their internships. Some participants described their academic training as too theoretical and lacking in exposure to practical engagement in communities. This was a barrier to their delivery of PMHC immediately after their academic training. Other participants stated that they regarded their academic training as a facilitator in their delivery of PMHC as it had provided them with valuable and important theoretical knowledge in the field of MH.

Many of the participants reported that the other element of their formal training, the acquisition of practical skills, occurred during their internships in under-resourced and diverse communities. Participants reported that skills acquired during their practicums included general supportive counselling skills, trauma debriefing and bereavement counselling skills, career counselling skills, anger management and resilience counselling skills, screening skills, and language and cultural awareness. The skills acquired by the participants were the appropriate skills for a RC employed in the delivery of PMHC, and can be regarded as facilitators. When participants reported that they had acquired the necessary skills during their internships rather than during their academic training, they attributed the acquiring of these skills to

internship sites, to supervision during their internships, and to working in multi-disciplinary teams during their internships.

Participants reported that the internships sites were mostly in under-resourced communities. The sites included hospitals, MH centres, police stations, NGOs, schools, private practices, drop-off and trauma centres and the Phelophepa Healthcare Train. The Transnet-Phelophepa Healthcare trains are free, mobile healthcare clinics that travel to and service remote rural areas in South Africa. Participants commended the internships sites because the sites were suitable for RCs as they learned important and useful skills there, and they were exposed to diverse communities and cultures. Thandiwe, a 34-year-old RC in full-time private practice, and Yibanathi, a 35-year-old RC in private practice, respectively described their internships.

> *"And also the actual uh practical that I had got to do in psychiatric hospital for 6 months. So that one for me stood out for uh... because I really learned a lot from that experience. And also even the trauma debriefing incidents that we were exposed to.... I learned a lot from that. And also the continuous uh supervision."*
>
> *"So I didn't find myself working with just maybe one culture, one race and that. I had exposure to working with different cultures. And I think that helped me when it came to my work now because I know a little bit about different cultures."*

In addition, participants spoke highly of their internships due to their positive experience of supervision at internship sites. They reported that the supervision was conducted by both individual and teams of MH professionals, and they had learned relevant skills by engaging with their supervisors or by observing them at work. The participants who worked in, and were supervised by, multi-disciplinary teams described the group discussions, debriefings, and learning about referrals as facilitators in their delivery of PMHC. This is how Maheen described her experience on the Phelophepa train during her internship.

> *"So it was just satisfying and then of course I had the safety of of the train. I had the safety of supervision, I had… I felt held in the process. Because we'd come back and we'd have debriefing, we'd have supervision you know, uh and we worked as a team - but we also had an opportunity to do individual work."*

A minority of participants reported a different experience of their internship sites. They were dissatisfied because there were either no internship sites in their area, or the sites were not in under-resourced communities where they could develop the skills necessary for community work.

An interesting finding was that two participants reported that they had acquired the necessary skills for competency only after their academic training and internships. They reported the acquisition of necessary skills occurred in practice after their registration with the HPCSA. Lesley, a RC in private practice most of the time since her registration with the HPCSA 12 years ago, explained this.

> *"I'm thinking through the practice itself - getting to know clients, different problems. Again contact with the actual community and the people that's coming for counselling. I think through that practical experience in the practice itself, and through self research basically. Not really through anything else."*

Other than skills, knowledge is an essential component of competency, and participants confirmed that they continued to further their knowledge to ensure their competency. They did so not only through further formal training such as reading master's or doctoral degrees, but through informal ongoing training. This continued formal and informal training, I identified as facilitators in the delivery of PMHC by RCs in full-time or part-time private practice because participants stated that they sought training activities that increased their knowledge, and so their competency in the field of PMHC and MHC. Participants explained that their informal ongoing training included Continuous Professional Development (CPD) courses, workshops, study and supervisory groups, and conducting individual research. This informal training furthered their knowledge in the field of mental health care, their knowledge and understanding of the mental health conditions of their clients and communities, their knowledge in relation to the particular focus of their practices, and their knowledge of private practice management. Ilse, a 32-year-old RC in private practice for 7 years, who held a master's degree, explained how she continued to improve her knowledge by participating in relevant groups.

> *"I'm part of quite a few groups where um we share information on the latest studies on sexual health and well-being. One is a multi-disciplinary group, um… and then there's a few psychology-based where I am the only RC. So I try my best to know as much as possible of what's happening in the world of research coming out of these areas."*

Kenneth, a 34-year-old RC in private practice for four years, recalled how being part of a group practice with other MH and health professionals provided him with not only valuable supervision, but new information and a consequent deepening of his understanding of MH issues.

> *"Also very informative. Um it was good it was good supervision in in those environments. They were very um ....they were very theoretical I would say. The works. It was never just a case of can.. of winging it. But there was always a lot of discussion about the the underlying um theory, group therapy, um fundamentals, and, you know, the the condition of anxiety, depression and and traumatic presentation as well. Um so ja, I learned a lot. A lot of the skills I learned there just in terms of skill-based work is what I use with my my clients now."*

I identified networking with other RCs and MH professionals via support groups as another enabler of PMHC as it broadened the knowledge and information base of some of the participants. Participants, who were part of social media networks, were positive about this medium and stated that they learned from one another and often exchanged information on these networks.

> *"For me, it makes me feel good because of the fact that I enjoy learning from other people who are also RCs. I'm learning so much from them. And I can always contact anyone of them and ask this and ask that."*

4.2.1.2 Awareness and delivery of PMHC

Participants reported that their positive disposition towards providing PMHC included their feeling competent to do so, as well as their knowing about the lack of awareness of MHC in diverse and under-resourced communities. This lack of awareness of MHC they regarded as a barrier to their providing assistance to those in need of MHC. As a result, participants saw themselves as promoting awareness of MHC, and reported that they were engaged in the delivery of MHC to communities when it was possible to do so. I identified the promotion of MHC and the delivery of MHC to communities by participants as facilitators in the delivery of PMHC.

Participants reported that, in their experience, there was a lack of awareness of MH issues and MHC in under-resourced rural and urban communities, in communities where MH was stigmatised, and by populations that were historically disenfranchised and poor. In these disenfranchised and poor communities, people did not have medical aid cover and could not afford the fees of MH practitioners.

Participants stated that the lack of awareness of MH and MHC in these different communities was a barrier to their delivery of PMHC. They reported that it was difficult to provide PMHC in these different communities because the lack of awareness of MH meant that there was a lack of knowledge and understanding of MH issues, a lack of knowledge about the counselling process, and little understanding of the different MH categories and professionals. Funeka, a 25 year-old RC in private practice and a member of a multi-disciplinary group practice, described how the lack of knowledge about MH issues and the counselling process, potentially jeopardised her providing MHC. She reported that clients misunderstood the role of the MH professional and process, and, in the limited number of sessions allotted to them, she first had to explain what MHC is, how the process works, and that it is not the same as visiting a doctor. The added risk was that clients could walk away from the required MHC. Funeka reported that these experiences had her focus her attention on the psycho-education of communities, and prompted her to enrol for a master's degree in the promotion of MH.

> *"It it's challenging because uh when when a client comes and talk about their presenting issue, you already plan ahead in how you go about uh helping them. But for them - it's it's ... they don't believe in this long-term process. For them they want immediate gratification. And making them to come back and telling that it's a process, they might just want to withdraw - 'cause it's not working for them."*

Mbulelo, a 27-year-old RC in part-time private practice and keen on providing MHC to under-resourced communities, allotted the lack of awareness of MHC to the insufficient number of MH professionals in communities.

> *"I think in my experience uh not enough MH professionals have worked in the in the community. I don't think there's enough um mental professionals that are in communities, that are doing the work in the communities."*

Participants reported that they knew that the stigma attached to MHC also added to the lack of awareness about MH issues and MHC, and that it was a barrier to their delivery of MHC. Participants related various instances where they experienced the obstructing effects of the stigma attached to MH issues and MHC. They reported that some people referred by the Employee Assistant Programmes (EAP) feared jeopardising their jobs if they attended more than one or two counselling sessions, and so they terminated counselling prematurely. In some

instances, participants reported that parents would not send their children for recommended MH counselling because of the stigma attached to MH services. In other instances, children refused to go for counselling because they had little or no knowledge of the process, and were ashamed of going. Bushra, a 46-year-old RC in private practice, reported that, in her experience, an increasing number of people were gradually realising that they had to seek help for MH issues. Some participants even reported that children and teenagers attached less or no stigma to MHC than adults. They stated that some young people were keen to see their counsellors, were comfortable with them, and discussed their experiences of counselling openly on social media.

Some participants stated that a RC stationed at every clinic or community health centre in the country would be a facilitator in the delivery of PMHC. A RC at every clinic or community health centre would reduce the stigma attached to MHC, would normalise visiting a MH practitioner, and make MHC more accessible. Ilse described this.

> *"But there are community centres all over, and if there was access... if every rec centre had a mental health room, with a RC at least, um it would make mental health less stigmatized or also more accessible."*

Participants reported that along with the promotion of MHC to counter the lack of awareness, they engaged in the delivery of MHC wherever they could. I identified the providing of MHC by participants to various communites as a facilitator in the delivery of MHC, along with their promotion of it. The majority of participants reported that they provided MHC to under-resourced communities. They stated that they delivered MHC from their private full-time or part-time practices and from their places of employment. Some participants that provided MHC from their private practices stated their clients were referred to them for counselling via EAPs such as ICAS' Health and Wellness Programme and Careways. These clients often were from low-income communities, and did not have medical aids or could not afford MHC. A participant described her EAP clients.

> *"But also if it wasn't for Careways that I could liaise with them again, it would've been a dead loss because they at least have the .. a space for RCs to be able to access people that necessarily can't afford it, but the company can pay for it."*

Participants reported that the typical facilitators of their delivery of MHC to diverse and under-resourced communities included not only providing counselling for individuals and families, but also included screening and assessment from their private practices, and psycho-education in communities. Participants reported that the psycho-education that they provided was via workshops and information sessions, and by writing articles that promoted MHC and explained MH issues. Participants reported that the workshops and information sessions included a focus on burnout related to HIV/AIDS, transpersonal practices, trauma stress release exercises, MH issues, the different MH professionals and the services they offer, sexual education and sexual well-being, anger management, self-awareness, and ADHD. Barbara, a 67 year-old RC in private practice for 10 years, ran her private practice as a multi-pronged business. Barbara described how she engaged different communities, and how workshops about MH and MH issues were facilitators in her delivery of PMHC.

> *“I 'd say... as I say last year, I worked for Social Development. … they had me in schools every single week. I I was just bombarded with workshop work, and I could barely see my clients - one-on-one in private practice 'cause: Sorry, I'm working all Saturday.”*

The articles that participants reported writing about MH issues and MHC were about the effects of Covid-19, relaxation exercises, self-awareness, anger management, and burnout related to HIV/AIDS.

Some participants reported that they also offered their services pro bono, negotiated their fees, or did voluntary work at community-based organizations in under-resourced communities. These services were further facilitators of the delivery of PMHC by participants, and indicative of their commitment to providing MHC . A participant, Funeka, who was an independent member of a group practice of health professionals in a township, informed me that the practice conducts a two-day wellness programme once a year. The participant and the other members of the group practice offer their services for free to the community for these two days. The services include consultations and psycho-education, and have proved to be very successful.

> *“But then on... in our practice last year we decided that every year, we are going to have two wellness days whereby we provide free consultations to the*

community. So yes, that's how myself and the team working in our private practice are giving back to the community. And educate them."

Another participant communicated with his community via a community radio station. He joined a talk show host once a week, and responded to questions about MH issues and MHC. This promotion of MHC he regarded as part of his private practice.

It is interesting that Nigel, a RC in private practice and a late-comer to the field of PMHC, offered all his services for free, and has been doing so for the past three years. A facilitator for him was that he was retired, and did not have to rely on the income that a practice would usually provide. Nigel reported that he viewed his delivery of PMHC to communities as giving back to the community after a certain age.

Some participants provided MHC to under-resourced communities via their places of employment. These participants simultaneously managed their private practices and were employed. Most of them were employed at schools every day of the week. They saw their private practice clients in the afternoons or at weekends. Most of the schools were in under-resourced communities. Participants worked with children and adolescents. Participants, in their work with the children and adolescents, did individual and family counselling, ran workshops and information sessions for learners, educators and parents. Their counselling focused on trauma, grief, crisis and career counselling. The workshops and information sessions included MH awareness, trauma management, social skills, Emotional Intelligence, self-esteem and self-empowerment, parenting skills, adolescent issues, study and exam skills and stress.

4.2.1.3 Beliefs about the role of the RC

The affirmative beliefs that participants reported about the role of the RC were in keeping with their positive disposition to provide MHC in diverse and under-resourced communities, and can be regarded as facilitators in the delivery of PMHC by RCs. These positive beliefs about this role included participants' perceptions of the RC as the first port of call for psychological assistance and appropriate referral, the RC as the MH practitioner responsible for psycho-education and the imparting of psychological skills, and the RC as accessible and affordable.

Participants related that as the first port of call for psychological assistance, they had an important role to play. Matthew, a RC in part-time private practice, spoke

positively of the RC as a first line defender, a definition that is in line with the definition of the RC by the HPCSA. Participants stated that intervening at this initial level was a facilitator in the delivery of MHC as it meant access to psychological services, provided early intervention to identify MH issues and assist those in need, and was the platform for appropriate referral. Kenneth, a RC in private practice and whose focus was employee wellness, summarised this.

> *"I see it as the first step in getting people into that system, and identifying and screening, and, you know, providing the initial um initial response. And then um and then from there, they they get to ...pointed in that direction that's going to be suitable for them - whether it's clinical, counselling psychologists, psychiatrists or anything along those lines. That that for me is is the value of the role."*

Other participants related that the early initial invention by the RC could help with the prevention of more serious MH issues developing and the consequent need for clients to engage in long-term psychological interventions.

In their appraisal of another facilitator in the delivery of MHC, the belief that the RC is the MH practitioner responsible for the the promotion of MH and MHC and for the imparting of skills, some participants stated that the primary role of the RC was indeed just this: psycho-education and teaching of psychological skills. These participants maintained that awareness campaigns and workshops presented by RCs provided people with information about MH issues, and underlined the need that individuals and communities take care of their mental health. In this, the RC provided important psycho-social support. These participants also stated that the psychological skills that the RC imparted assisted people with the identification, understanding and management of every day challenges.

A number of participants stated that the role of RC was important because the RC was accessible and affordable. Accessibility and affordablity can be regarded as facilitators in the providing of MHC by RCs. Yibanathi, a RC in private practice who spoke six South African languages and was passionate about assisting different communities, explained this by pointing out how accessibility facilitated providing MHC to communities. According to Yibanathi, people could consult RCs directly and did not have to do so via bureaucratic protocols such as those at hospitals. For her, she said, the RC was a phone call away, and this accessibility of the RC made it easier for communities to consult RCs..

> *"And just being able to to connect with them on the ground where they are - they don't have to to go through the process of going into a hospital, getting a patient number just to see um to see us. They can access us at any time. I think for us we are so accessible and that makes us the people that are loved by the communities."*

Other participants confirmed that RCs were not only accessible, they were also more affordable than, for example, psychologists. They reported that the consultation fee of the RC is lower than that of the psychologist, and this made MHC more possible for people with financial constraints or no medical aid. Some participants added that alongside accessibility and affordability, RCs also did pro bono work in communities.

An interesting finding about the beliefs of participants with regards to the role of the RC was that some participants regarded the name of the category as a barrier to the delivery of MHC by RCs. The participants referenced MH professionals in Australia and New Zealand, with similar qualifications as the RC in South Africa, who went under the title of General Psychologist. They reported that renaming the category would facilitate the delivery of MHC to communities as people and other MH and health professionals would understand the role and engage RCs more easily. Some participants added that the role of the RC was to ease the pressure on other MH professionals such as psychologists, and the renaming could facilitate that development.

Two participants, in their reporting about their beliefs about the role of the RC, identified a barrier to the delivery of MHC by RCs. The barrier was the belief that there was a lack of role clarity and positioning of the RC within the field of MH. Ilse, a RC in private practice with a particular interest in the queer community, stated that she had mixed feelings about the role, and, when asked by people about her role, she merely said that she worked with mental health. Lesley, a RC who experienced a greater understanding and engagement of RC in an urban environment, reported that for her the original role and focus of the RC had changed so much that she had had to redefine the role for herself. In her role as a RC, she could no longer focus on her avid interest in and passion for community work, and had to develop a particular focus, a niche, that provided her with a viable livelihood.

> *"You know, in essence, you move on and eventually you try to just do what you can, and add value from a RC point of view as far as you can. But eventually it becomes something else. You develop your practice into something else in*

terms of focus and vision. So I don't think uh I don't think initially - you know - um what we set out for became a reality. And it's it's part of that thought that one then just develops your own niche basically."

In summary, participants reported that they had the knowledge and skills to deliver PMHC to diverse and under-resourced communities. Where they lacked skills or knowledge after their training and practicums, they had acquired these while in practice via CPD courses, workshops, discussion and study groups, networking and their own research. Participants also reported that they promoted and provided MHC in communities, and the majority of participants believed in the value and importance of the RC as a MH professional. These findings were identified as facilitators in the delivery of PMHC and MHC by RCs in full-time or part-time private practice.

4.2.2 The RC as an unacknowledged MH professional

Participants reported that, in their experience, the RC was largely an unknown MH professional, and little was known about the role and the scope of practice (SOP) of the RC. I identified this lack of knowledge and understanding of RCs as a barrier to their delivery of PMHC. I discuss this theme according to three sub-themes. The sub-themes are (1) lack of knowledge and recognition of RCs, (2) lack of support by other MH and health professionals, and (3) consequences of oversight.

4.2.2.1 Lack of knowledge and recognition of RCs

Participants reported that a common and critical barrier to their delivery of PMHC was the lack of knowledge and recognition of this MH profession. They stated that the RC category was either unknown to or not recognized by various relevant structures and bodies which included government departments and government institutions such as hospitals, clinics and schools, other MH and health professionals, communities, the HPCSA, medical aids, and certain NGOs.

Participants described this barrier, the lack of knowledge of the RC as a MH professional, as recurring and widespread, and reported that typical responses included a lack of knowledge and understanding of the RC category, of the SOP of the RC, and of the services rendered by RCs. Another typical response, they stated, was the lack of recognition of the category. They reported that this lack of recognition by different structures and bodies was a barrier to their delivery of PMHC because it resulted in RCs not being employed by government departments or government institutions, not being engaged by, or referred to by other MH and health professionals, their qualifications not being accepted by medical aids, and

communities not making use of their services. Mbulelo, a RC in part-time private practice and frustrated at the lack of community work, related that the lack of knowledge and recognition of the RC meant that he had to explain the profession and its relevance in the health sector to some MH and health professionals, but that he often met with little success. Mbulelo reported that he felt that he constantly had to fight for recognition, and this left him feeling annoyed and demotivated.

> *"I think other health professionals do not know about us, firstly. And I think um if you explain to some of the professionals, they still don't understand. They they they.... some of them feel uncomfortable. So you ... and then as a result, some of them are even uncomfortable with referring clients um to you or recommending you because they actually... they they do not understand what ... who you are and what you actually do. What you actually bring to the table in in in the health sector."*

Funeka, a RC who could not find employment in the public sector despite being keen on community work, reported that, in her experience, government did not recognize RCs, and preferred employing psychologists. For Funeka, this lack of recognition of RCs by government was not only a barrier to her delivery of PMHC, it also funnelled her, initally reluctantly, into private practice. Funeka reported that, in her experience, RCs were particularly well suited to be employed by government as RCs were trained to provide primary intervention, knew when and how to refer appropriately, and could take the pressure off psychologists in government hospitals and clinics. She also related that the employment of RCs by government would help normalise and facilitate MHC in communities.

> *"Looking at employment, uh I think for me private practice wasn't the way to go because I I wanted to be working with the community being employed by government. But we are not recognized as RCs. They want psychologists. And for me, I thought we are employable as RCs because we can provide the type of intervention And also looking in in government hospitals, you find that there's only one psychologist. And for them, it's also pressure. So if they can use us RCs, MH can be a norm to people. People will know about it. Private practice was my second option."*

Some participants reported that they experienced a lack of recognition and, hence, support at schools, and that this was a barrier to their providing PMHC. Bushra, a RC in a part-time private practice, and employed at a school, stated that,

in her experience, the Department of Education in the province where she was employed, preferred to employ either psychologists or social workers, rather than RCs. Hazel, a RC whose focus was on intervention in educational settings, reported that a Department of Education International Baccalaureate (IB) programme initially turned down a consensual application from her because they did not recognize the qualification or competency of the RC. Hazel described her experience of this, and relegated this lack of recognition to a lack of knowledge about the RC category and SOP.

> *"I do um special consensuals ... consensual applications and one for Department of Education IB. And IB actually said they don't recognize RCs to be um competent or trained to take down scholastic tests. Um so I did make a big noise about that. Eventually they did accept me, but they said... generally they don't accept our qualifications. So just gives me the idea how little um people know about our services and what we do provide and what we are trained for."*

Paula, a RC also in part-time private practice and employed at a school, reported that the staff at the school did not understand the role and SOP of the RC, and often confused RCs with social workers. A number of other participants also reported this confusion of the one with the other. The confusion of the RC with the social worker was a barrier to the engagement or employment of RCs, and often meant that RCs missed out on opportunities to provide PMHC. Conversely, as was the case with Paula, all the social work was erroneously referred to her until she could convince authorities that that was not her field of expertise.

> *"They get very confused at ... in the beginning.... eh uh although you know, I've explained and showed my scope of practice, and what what. They ... they get confused with us and social work. In the beginning, they kind of referred all the social work to me - and I said that's not actually what I am doing."*

Some participants reported that RCs were often confused with social workers or psychologists, as well as lay counsellors. These participants indicated that there were a number of reasons for this confusion. The reasons included a lack of knowledge about the formal four-year academic training and SOP of the RC, the lack of registration with the HPCSA that some training institutions did not insist on, and the name of the category which did not immediately indicate that the RC was qualified in the field of psychology. The participants regarded this confusion with lay

and other counsellors as a barrier to the delivery of PMHC as, again, RCs were not employed or engaged in appropriate settings where they could be of service. Thandiwe, a RC who was employed at a rural hospital before she started her full-time private practice in an urban area, described her experience of the lack of knowledge about the formal academic training of a RC.

> *"And I also remember the clinical psychologists were not even uh believing the fact that we were introduced to the DSM IV. But again we would be trained, at this stage, you cannot diagnose. But this is to guide you to know that this is the kind of client that you are dealing with so that you are able to refer. But to them it would seem like if they are dealing with us, we are just lay counsellors who doesn't...who can't even see or or identify your your your pathologies that are... that your client has*."

Some participants reported that the lack of knowledge and recognition of the RC was also reflected in the referral system in the field of health and mental health, and identified this as another barrier to their delivery of PMHC. They reported that the referral system in the field of mental health often did not acknowledge or engage the RC. Some of the participants had encountered questioning of their formal academic qualifications and acquired knowledge of pathologies when they referred clients to other MH professionals. Participants reported that identifying pathologies was part of their training, and it is for this reason they could refer clients when it was necessary to do so. Yibanathi, who, in emergencies, had repeatedly tried to refer clients to hospitals, described her experience of this barrier. She reported that the hospitals did not accept her referral, and this meant that her clients would have to admit themselves. Yibanathi reported that she then did not know whether clients actually did have themselves admitted. Yibanathi explained that she resolved the recurring situation when she located clinical psychologists at the hospitals who agreed to help her with the admission of her clients, but it left her feeling disempowered and extremely disappointed in the system.

> *"For me at times, would be when you having emergencies, and you need to to refer immediately. Maybe to the nearest psychiatric hospital and that. And, like I said, at times being a RC is not recognized. So it's... you're referring because it's something urgent, but the person on the other side is ... is saying: but who are you? How how is it that you want to refer this person to us?"*

Paula, in her description of her experience of the referral system, stated that it was a barrier to her delivery of PMHC because clients that she had to refer got lost in the system, and missed out on the MHC they needed. For Paula, a less restrictive SOP of the RC would mean she would not need to refer early, and would be able help the clients herself. Maheen, a RC employed part-time at a school, related that she had to discourage teachers at the school from sending her learners for assessment and referral, as her referrals were not considered or accepted by MH professionals employed by government.

4.2.2.2 Lack of support by other MH and health professionals

The majority of participants reported that they did not feel supported by other MH and health professionals when they, as RCs, attempted to provide PMHC. Participants identified this lack of support as another barrier to their assisting individuals and communities in need of MHC. Participants explained that the lack of support revealed itself a number of ways which included the belief of other MH professionals that RCs were a threat to them, other MH and health professionals not engaging the services of RCs as fellow MH professionals, and negative attitudes and perceptions of RCs by other MH professionals.

Participants stated that, in their experience, other MH professionals, in particular psychologists, regarded RCs as a threat. In their understanding, psychologists were concerned that RCs could replace them and so threatened their livelihood and profession. Participants added that there was also a general competition for resources among MH professionals, and this, in their opinion, led to professional jealousy and MH professionals protecting their professional turf. This resulted in a lack of suppport for RCs, and was an obstacle to the often passionate interest and commitment of RCs to provide PMHC. Lesley, a RC who was passionate about community MH awareness and delivery, described her marginalization by other MH professionals when they attempted to prevent her from participating in providing MHC and awareness by removing her board that advertised her services.

> *“Because a lot of the clinical psychologists in the hospital that I wanted to collaborate with - they um they're not open, and they want to have the pre pre predominance in terms of who comes and who goes. And they even try to take off my board. They tried to take that off, but it didn't work because I had a permit and permission.”*

Another barrier to the delivery of MHC by RCs to under-resourced and diverse communities was the lack of engagement of the services of RCs. Participants reported different examples of this oversight. Some participants stated that RCs were often not part of the MH and health referral systems. They described their experiences with psychologists, general practitioners (GPs), and other medical specialists such as gyneacologists and paediatricians who had not referred clients to them although the participants felt that they could assist, and had made the practitioners aware of their professional services and practices. Barbara, a RC who had worked extensively in under-resourced communities, stated that, in her opinion, the psychology profession did not understand the needs of people in under-resourced communities, and that psychologists were not managing to cope with them. For Barbara, the RC was particularly suited to assisting in under-resourced communities, but other MH professionals did not really care about the RC, let alone refer clients or community work to them. Mbulelo, a RC in part-time private practice, also described his experience of this barrier, and allotted the reluctance of other MH and health professionals to refer clients and community work to RCs to their lack of knowledge and understanding of the RC category and RC SOP. Anton, a RC who experienced being a threat to psychologists, concluded that the RC and psychologist would continue to function separately as psychologists did not engage the services of RCs as MH professionals.

> *"The two… the two are separate. One would think that if I go to a doctor, then he would refer me to a speciallist. And the specialist would be someone with a -logist behind their name – to put it like that. And one would expect that system would work in South Africa as well. You first see a RC, who then refers you to a psychologist, and who perhaps refers back to the RC. But it doesn't work like that." (Translated)*

Many participants regarded the negative attitudes and perceptions of other MH professionals in relation to RCs as a barrier to their delivery of MHC to diverse and under-resourced communities. Participants reported that the unfavourable bias of other MH professionals, in their experience, manifested in a number of ways. These included a lack of knowledge and support of RCs, a perceived fear that RCs would work beyond their SOP, and the RC role regarded as inferior, sometimes irrelevant. Participants reported that the negative attitudes of other MH professionals also translated into a perception that RCs were not legitimate MH professionals, and,

therefore, there was a lack of interest in interacting with them. Some participants reported that these negative attitudes and perceptions adversely affected them and how they worked. A minority reported that they were unperturbed by this adverse reaction to them and their work.

A minority of participants, who reported working in multi-disciplinary teams, also reported that, in that immediate environment, other MH and health professionals did engage and interact with them, and refer clients and community work to them. They reported, however, experiences of lack of knowledge and support by other MH and health professionals outside of the multi-disciplinary teams, and this was in keeping with the experiences of participants in solo private practices.

4.2.2.3 Consequences of oversight

Participants, in their response to the general lack of recognition and support by various relevant structures and bodies which included government departments and government institutions such as hospitals, clinics and schools, other MH and health professionals, communities, the HPCSA, medical aids, and some NGOs, described their feelings about this oversight, and the effects the oversight had on them.

The majority of participants reported negative feelings about the lack of recognition and support. Although the adverse feelings of the participants did not prevent them from promoting awareness of MH and MHC and providing MHC in communities, the negative feelings, at times, did challenge their motivation to continue, and were potential barriers to their engaging the profession. They stated that at different times they had felt inadequate or inferior, frustrated, angry, disillusioned, disappointed, disempowered, and demotivated. They explained that they had experienced these adverse feelings when they were excluded from referral systems, community work, employment by government and the private sector, and when they had to fight for recognition by and engagement of other MH and health professionals. In some instances, a number of participants reported that the lack of recognition and support for them as MH professionals was eroding their passion for the delivery of MHC to communities, and, that, at times, they considered leaving the profession. Lesley, a RC who regarded the profession as a calling, described how the lack of recognition and support of RCs made her uncertain about her choice of the profession.

"You start questioning your... you start questioning your initial calling and the value, and wonder... You begin to doubt whether it was the right thing to do. Should you still continue? Are you not...uh.. flogging a dead horse? Should you continue with a doctorate? Or should you actually go into a whole other field?"

A minority of participants stated that they were not immediately affected by the lack of recognition and support from the various structures and bodies because they either worked in multi-disciplinary teams or they were part of support groups with other MH professionals. In both instances, they were engaged in referrals, discussions and MH awareness and MHC delivery programmes. These participants concurred, however, that, in general, RCs did not receive the necessary and important support and recognition that they needed, and that this was a barrier to their delivery of MHC in communities.

Participants also reported the effects that the lack of recognition and support had on them. Some participants stated that the oversight did not affect them because they felt confident about their abilities, their choice of the profession, and the assistance that they provided to their clients. These participants related that the lack of recognition and support was not a barrier to their delivery of MHC to communities. Instead, the effect it had on them was that it made them work harder and as thoroughly as possible to ensure that they gave their best to their clients and the RC profession. Mbulelo, who experienced the running of only a part-time private practice as limiting his delivery of PMHC, described the effect the lack of recognition and support had on him.

"I think um for me - it influences the way I work in the sense that I work harder. I find myself working harder ... I find myself even with my clients - when I work with clients - I give them my 100%. I I put in 100%. I make sure that my consent form is 100%. I do my best um because when they leave, and someone asks them : Wait, did you go to a psychologist? Then they are like: No, I went to see a RC."

Some participants reported that, although the lack of recognition and support was not a barrier to their delivery of MHC to communities, there were instances when they were negatively affected by the oversight. These participants related that the lack of engagement and acceptance of referrals that they made to other MH and health professionals delayed assistance to those in need of MHC. This left the participants feeling frustrated, undermined and demotivated. The participants

reported that it was the importance of assisting their clients that motivated them to continue practising despite this kind of barrier. Mbulelo, a RC in part-time private practice who could reduce his fees because he had other employment, related his experience of the oversight by other MH and health professionals.

> *"Uh... Ok. I think they do not know about us, firstly. And I think um if you explain to some of the professionals, they still don't understand. So ... and then as a result, some of them are even uncomfortable with referring clients um to you or recommending you because they actually... they they do not understand what ... who you are...and what you actually do. What you actually bring to the table in in in the health sector. So, ja. ... I think it makes me feel frustrated as a person because uh I constant... I constantly have to fight. And it becomes frustrating. It becomes draining. That makes me feel angry, frustrated and uh sometimes, it makes me feel demotivated. At some point, I felt demotivated."*

A participant reported that the lack of recognition and support, which also limited her access to her passion, supportive counselling and psycho-education in under-resourced communities, made her shrink her practice focus to assessment so that she could make an income without too many obstacles.

Some participants related that the lack of recognition and support by other MH and health professionals had spurred them on to continue their academic training. These participants regarded the higher academic qualifications as facilitators because these would ensure greater respect and dignity for the category, or provide RCs with more authority to engage policy and regulation of the RC category. The majority of participants either held or were enrolled for master's degrees. One participant held a doctorate.

Some participants reported that their response to the lack of recognition and support was to take care not to fall into the trap of thinking of the RC as a lesser professional. Instead, they reported that they took pride in their work, worked within their SOP, acquired as many skills as they could via workshops and CPD programmes, and tried to develop a niche in the psychology profession.

In summary, participants reported that, in their experience, the RC was a largely unknown MH professional. They stated that there was a lack of knowledge about the role and SOP of the RC, and a lack of recognition and engagement of RCs by the public and private sectors. Participants identified this lack of knowledge and

recognition, as well as the lack of support by other health professionals, as barriers to their delivery of MHC to various communities.

Participants reported negative feelings about being overlooked and unacknowledged by the public and private sectors. Most of the participants revealed that this oversight affected their delivery of PMHC. Other participants stated that the oversight motivated them to work harder and further their formal academic training.

4.2.3 Limited option other than private practice

Participants reported that there were very few employment opportunities in the public sector for RCs and that this was a major obstacle to their provision of PMHC. This theme consists of three sub-themes. These are (1) no or very few positions in the public sector, (2) preference for other professional categories, and (3) limited alternatives to private practice.

4.2.3.1 No or very few positions in the public sector

Participants agreed that there were no or very few positions created by government for RCs in the public sector. For most of the participants this was a barrier to their delivery of PMHC, and a source of frustration and disillusionment. Participants attributed the lack of positions for RCs in the public sector to various reasons. These reasons included little recognition or understanding by government of RCs and what they do, priority given to the funding of psychologists and social workers, and the financial inability of government to fund positions for RCs in the public sector.

In her interview, Yibanathi, who sometimes experienced the administration related to a private practice overwhelming, reported her experience of a lack of recognition or understanding of RCs by government, and the preference of government to fund posts for psychologists. Keen to work in the public sector, Yibanathi related that she had located very few advertisements targeting RCs. Her applications, for the few positions she did find, went unheeded.

> *“Ja. I did but uh one, there's very few jobs advertised in that sector. And you just never get a response if I can put it like that. There's never a response. Um because I don't think the understanding of the work that we do was there. The only time you'd see an advert would be for a hospital, for a clinical psychologist.”*

Another participant, Maheen, a RC in private practice for two years, and actively engaged in under-resourced communities before that, reported her first-hand

experience of the lack of government funding for the positions for RCs. Maheen was employed part-time at a school in an under-resourced community. Her post as a RC at a school was a school governing body (SGB) post. There was a real need for PMHC at the school, but Maheen could be employed for only half a day, once per week, as the school could not afford more than that. Maheen described this barrier to her delivery of PMHC with some disillusionment.

> *"Then the school that I work in, there is a need - but can only employ me half a day, a one day a week. Right, and that is the school hours. … The the Department of Education will not recognise me. It's almost like I'm just there, I'm a governing body post*."

Most of the participants, adequately trained and eager to provide PMHC , experienced the lack of job opportunities as a crucial barrier to their fulfilling the role of the MH practioner tasked with delivery of PMHC. Matthew, a RC in private practice for four years, described the frustration and disillusionment that many RCs felt at the lack of job opportunities in the public sector.

> *"Yes. There's a lot of frustration from that aspect because then what is the use for this category then. So there's a lot of conflict from that point where people feel that - Ok. Why did we train? Why did we study so hard? And now we are not able to do what we are trained for? So there's frustration from that end. And towards the HPCSA, the government and the various role players."*

Paula, a RC in private practice for seven years and who benefitted from good supervision during her practicum in under-resourced communities, was in private practice in a well-resourced community. Although Paula did not feel pressured to provide PMHC in only under-resourced communities, she attested that RC positions created and funded by government in the public sector with the required resources would be ideal.

4.2.3.2 Preference for other professional categories

Participants reported that, in their experience, RCs were often overlooked in favour of other MH professionals, in particular, clinical psychologists and social workers. Participants stated that RCs were overlooked by government departments, hospitals, clinics, schools and some communities. Participants reported that they experienced this preference for other professionals by these institutions and structures as a barrier to their delivery of PMHC.

Participants who wanted to work for government in communites, whether in hospitals, clinics or schools, related that securing such positions was not easy and, sometimes, impossible. Barbara, who ran a busy private practice and worked mostly in communities, described the process of finding work in government as a potential barrier to the delivery of PMHC in under-resourced communities. She explained that she had overcome this obstacle once she understood that she needed to use a registered service provider to access work from government. In her opinion, a RC with only an Honours degree, had little chance of becoming a service provider because government preferred employing psychologists, possibly because psychologists were better qualified than RCs.

Despite being able and keen to work in under-resourced communities in state schools, state hospitals, public clinics, participants continued to encounter a preference for psychologists by government, and, at times, by communities themselves. Matthew, a RC who was passionate about assisting low-resourced communities in need of PMHC, described his experience of this barrier to his delivery of PMHC.

> *“To be able to engage purely in community work - there is a lot of road blocks because you can't always engage. Where are we able to work? We can't always go to um MH clinic in a local community to say : OK. Let me help. Because uh being able to go and work there is - they don't always accept people. They feel that they need more psychologists. They feel that RCs aren't good enough. So even though the category was created for community-based work, they don't allow RCs to actually work in communities as such.”*

Although participants indicated that they understood the different SOPs of RCs and clinical psychologists, they were clear that they had an important contribution to make to MHC in diverse communities in South Africa. Yibanathi, a RC in private practice and keen to assist young people, was adamant that RCs were of paramount importance. Participants related that, in terms of their SOPs, they understood that they were the first port of call for those in need of MHC. They concurred that they were trained to do initial screening and assessment of clients, and, when necessary, knew how to refer appropriately to psychologists or psychiatrists. Participants related that as RCs they wanted to work with and alongside clinical psychologists and other health professionals. Some participants stated that, in their experience, they were not employed or engaged with because they were not psychologists, and clinical

psychologists were preferred, or because clinical psychologists were better qualified than RCs.

Participants also reported that RCs were overlooked in favour of social workers. Both professions require a four-year degree. Both professions are community-oriented. A participant, Bushra, proposed that social workers were preferred to RCs because the academic training of social workers included practical work from the beginning of the degree. This was not usually the case in the academic training of RCs, especially not at state universities.

> *" When it comes to uhm uh uh uh um uh whenever there's a need for counselling, uhm especially with with with organisations they find, there's sort of uhm preference given to a social worker as opposed to a uh registered Counsellor. … I think the understanding is there's too little training that a registered counsellor has as opposed to a social worker. The social worker gets more um they they think uh uh well I mean their course involves lots of uhm uh practical work - from the beginn- from the onset whereas counsellors I don't think that they receive so much practical experience - in their degree, in their training."*

Participants revealed that they were overlooked in favour of social workers in a number of instances, and that this limited or prevented them from providing PMHC in under-resourced communities. Bushra reported that, in her experience, the Western Cape Education Department (WCED), for example, did not appoint RCs at schools and seems to prefer appointing educational or counselling psychologists and social workers at schools. Bushra allotted this to the RC being regarded as the least important professional in the MH field.

Lesley, a participant enrolled for a master's degree in psychology, applied for posts at public hospitals – one of the designated places of employment for RCs according to government. She was not accepted, and was informed that preference was given to social workers. In another attempt to engage the community and promote MHC with a presentation about HIV/AIDS, Lesley was unsuccessful yet again as the hospital informed her that they had their own social worker and did not require her services.

A number of participants related their surprise at the choice of social workers by government to do psycho-social interventions and individual and family supportive counselling during the Covid-19 crisis in South Africa. They stated that RCs, whose

SOPs encompass these services, could just as well have been deployed, or deployed as part of the endeavour. Paula, a RC whose focus was trauma and grief counselling, described this development.

> *"I see now during lockdown that the government wants to deploy a lot of social workers. But government could just as well have deployed us…because I think that we can do many… we do a lot of work that overlaps with social workers, but that's the work that we can do. Sometimes, it feels to me, as if they think social workers can do everything. And then they use only them." (Translated.)*

Participants stated that social workers were not only preferred to RCs, they also had more authority than RCs. Participants provided examples of this. Other than a psychologist or psychiatrist, a social worker may the sign the 72-hour admission form for a client to be admittted to hospital for psychiatric examination. A RC can only sign the form as an associate of the client. Some participants reported that they experienced this limitation as a frustrating barrier to their delivery of PMHC. Maheen, a participant passionate about MHC in under-resourced communites, was in the dark why RCs could be supervised by social workers, when there was very little difference in the length of the academic training of these two professions.

4.2.3.3 Limited alternatives other than private practice

The majority of participants stated that they had started a private practice because they could not find employment in the public sector. Participants, who were keen to provide PMHC in the public sector, expressed their frustration and disillusionment at the lack of positions, and regarded this lack of employment opportunities as a barrier to their ability to provide PMHC. Most of the participants reported that they had responded to government's directive that the profession of RC would scale up MH services and promote MHC in diverse and under-resourced communities. Instead, as one participant stated, it appeared to be a failed mission. For these participants, the starting of a private practice was a second option – sometimes even an unwelcome second option. Participants related that they had spent time and money on the required training, and then, once qualitifed, they needed to make a living and contribute to their households or, as breadwinners, provide for their families. No or very few employment opportunities in the public sector necessitated the choice of a private practice to make a living. For some participants, this choice of a private practice negatively affected their delivery of PMHC, and was regarded as a barrier to doing what they were trained for and

passionate about, namely community MHC in diverse and under-resourced populations. This was how Thandika, who was familiar with the needs of people in under-resourced communities, described her experience in relation to the above.

> *"As a person, I would have loved to really really do uh uh ... to the communities. But real it is - I need to earn an income. And bear in mind, excuse me... Some of us are ... or most of us, you grew...you grow up studying and already having responsibilities. So the moment you graduate, you are expected to have an income, and not only for yourself. But for the family."*

It was clear to most participants, some of whom were not reluctant about operating a private practice, that their training had not prepared them to run a private practice. These paticipants reported that this was a barrier to their providing MHC in communities, especially at the beginning of their careers as private practitioners. The challenges at the beginning of the private practices related to the requirements, the expenses, and a lack of know-how about managing a private practice, and elicited different reactions in participants. Some felt unprepared, others incompetent and overwhelmed. Anton, a RC in private practice who had read a master's degree in business administration (MBA) after qualifying as a RC, regarded his lack of experience and exposure to a corporate and entrepeneurial environment as one of the biggest mistakes he made. Yibanathi, feeling that she was not doing her best because it was difficult to deliver PMHC from her private practice, had, at times, considered leaving the profession.

Participants, already feeling challenged by the day-to-day management of their private practices, reported that most of them also had to take on extra employment to supplement their income from their private practices. Places of employment did not always relate to counselling or psychological services, and participants conveyed their dissatisfaction with this development. They regarded the extra employment as another barrier to their delivery of PMHC for various reasons. The place of extra employment was time- and energy-consuming, often not in the field of MHC, and sometimes undermined their passion for their profession. Participants that were employed alongside their private practices, ran their practices after-hours and at weekends. The PMHC that they could provide was to EAP clients, and was limited. Lesley, who regarded her role as RC as a calling, stated that being confined to only this way of providing PMHC was a barrier to her delivery of PMHC, and resulted in a daily struggle within her. She reported this made her feel alienated from the

community. She was torn between adding value to the community and earning a livelihood.

Overall, the lack of employment opportunities for RCs led to feelings of disappointment, annoyance, conflict, a sense of inadequacy and uncertainty, and a sense of letting communities down. A few participants related that no employment prospects or guidance after their training made them feel abandoned and irrelevant.

> *"I don't know... it just feels like ...I feel like RCs are are ...You know, they sell us dreams, and then they dump it. You wake up. Um I'm not sure if the government knows what RCs are for."*

A number of participants, at one point or another, considered leaving the profession, citing that the many unanticipated obstacles were eroding their passion for the profession.

A few participants did not feel conflicted about being in private practice and not providing MHC in under-resourced communities. Although these participants were aware of the initial intention of the RC category, and agreed that there a need for PMHC in under-resourced communities, they did not feel pressured to do so, did not regard that focus as their calling, or had always been clear that their focus was elsewhere. These participants indicated that they had their minds set on specific interests from the beginning, or developed these interests while in practice. These interests included sport, employee wellness, sexual education and sexual well-being, self-awareness, anger management and ADHD counselling. These participants practised largely in well-resourced communities.

In summary, participants reported that there were no or very few employment opportunities for RCs, especially in the public sector. They ascribed this to a lack of knowledge, promotion and funding of the RC by government, and the preference of government for psychologists and social workers. Participants reported these oversights as critical barriers to their delivery of PMHC. The majority of participants also revealed that, despite being well trained for and passionate about community work, they had no other choice but to start private practices. They stated that they started private practices as they had to make a living, and had to warrant the time and money spent on their training. For some of these participants, their private practices limited their delivery of PMHC to under-resourced and diverse communities.

4.3 Conclusion

In this chapter, I described the findings of my study. I identified facilitators to the delivery of PMHC by RCs in private practice, as well as critical barriers that negatively impacted on the ability of RCs in private practic to provide PMHC in under-resourced and diverse communities. I included a visual representation of my findings in Figure 2. In the next chapter, I discuss my findings, and employ the Capability, Opportunity, Motivation (COM-B) model and the Theoretical Domains Framework (TDF) as theoretical lenses to explore the barriers and facilitators that the participants reported in relation to their delivery of PMHC.

Chapter 5
Discussion

5.1 Introduction

This chapter provides a discussion of the key findings of this study. The aim of the study was to explore the perceived barriers and facilitators in the delivery of primary mental health care (PMHC) to diverse and under-resourced communities in South Africa by registered counsellors (RCs) in private practice. I interviewed 19 participants, and employed thematic analysis to analyse the data. Three key themes emerged from the data, namely (1) positive disposition among RCs to engage communities, (2) the RC as an unacknowledged MH professional, and (3) limited alternatives to private practice.

5.2 Integrating theory and findings

I used the Capability, Opportunity, Motivation (COM-B) model and the Theoretical Domains Framework (TDF) to structure my findings. I used the TDF as it assisted with understanding behaviours theoretically, and provided a more detailed evaluation of barriers and facilitators that influence behaviour than the COM-B model on its own. The domains of the TDF (see Chapter 2) further informed the three components of the COM-B model, which indicates that behaviour (B) is the result of the interaction between the individual's physical and psychological capabilities (C) when they engage environmental and social opportunities (O) as a result of their reflective motivation and their emotions (Alexander et al., 2014).

Participants reported on factors that related to their physical and psychological capabilities (physical skills, knowledge, and memory, attention and decision processes in the TDF), their reflective and automatic motivation (professional role and identity, beliefs about capabilities, beliefs about consequences, optimism, goals, and emotion in the TDF), and the physical and social opportunities (environmental context and resources, and social influences in the TDF) available to them in their provision of PMHC to communities. Facilitators reported by the participants were mainly linked to their capability and their motivation, in particular, to their knowledge, awareness and skills, their professional role, and their beliefs about their capabilities. Barriers reported by participants were largely related to a lack of opportunity, specifically to environmental and social context. I will now describe the facilitators and barriers that were reported by participants in this study in more detail.

5.2.1 Capability as a facilitator (Knowledge, skills, memory, attention and decision processes)

Participants in this study reported that they possessed both the physical and psychological capability to provide PMHC to communities. They reported feeling competent to provide this service because they had the appropriate knowledge and skills to do so. Participants attributed these capabalitites to their formal academic training, their ongoing informal training such as continuous professional development (CPD) programmes and collegial networking, good supervision at suitable internship sites, and the experiences at their own private practices. In this study, participants related that they employed their knowledge and skills at their private practices and at places of employment, particularly schools. The majority of the participants stated that they provided supportive interventions for individuals and families, psycho-education to promote mental health care and well-being, screening and assessment, and appropriate referrals in diverse and under-resourced communities. These psychological services are in line with the scope of practice of the RC within the context of primary mental health care (HPCSA Form 258, 2019). In their commitment to the profession, some RCs reported that they offered their services pro bono, negotiated their fees, or did voluntary work in communities.

Similar findings were reported in other studies on RCs in South Africa. Several studies reported that RCs were well trained and adequately qualified to provide PMHC in diverse settings and communities (Abel & Louw, 2009; Elkonin & Sandison, 2006; 2010; Fisher, 2017; Kotze & Carolissen, 2005). Participants in these studies reported that the academic training had largely been appropriate and helpful, and that the skills acquired during their training and supervised practicums were pertinent. Furthermore, studies revealed that RCs were not only adequately trained and interested in PMHC, they were capable of providing supportive counselling to individuals and groups, promoted MH and the prevention of MH issues, engaged in psycho-education and the designing and presentation of MHC activities and programmes (Able & Louw, 2009; Elkonin & Sandison, 2006; 2010; Fisher, 2017; Kotze & Carolissen, 2005; Rouillard et al., 2016).

Participants in the current study also reported that they understood and were aware of the need for PMHC in under-resourced communities. They stated that the lack of awareness about MH and MHC prompted them to promote and provide PMHC when they could. Participants attributed the lack of awareness of MH and

MHC to a lack of knowledge about MH in under-resourced communities, to the stigma attached to MH, to the inadequate number of MH professionals in communities, and to the omission of a RC stationed at every clinic and community health centre in the country.

Other studies also reported that RCs demonstrated awareness of the need for MHC in diverse communities in South Africa (Fisher, 2017; Rouillard et al., 2016). Roulliard et al. (2016) established that RCs themselves were aware of the shortage of MH professionals, and the urgent need for the services of the RC.

5.2.2 Motivation as a facilitator (professional role and identity, beliefs about capabilities, beliefs about consequences, optimism)

Participants in this study reported that they were not only capable of providing PMHC, they were also motivated to do so. In the behaviour system of the COM-B model, capability and opportunity influence motivation, and motivation indirectly affects capability and opportunity through behaviour (Smith et al., 2019). The majority of participants reported that both reflective and automatic motivation played a role in their delivery of PMHC. In terms of their reflective motivation, these participants relayed their understanding of their professional role and identity as mental health (MH) practitioners, their positive beliefs about their capabilities, their beliefs about the consequences of their constructive contribution to the field of MHC, and their confidence in their abilities. The participants identified these attributes as facilitators in their delivery of PMHC.

The majority of participants in the study reported positive beliefs about the role of the RC, and stated that they were capable of fullfilling this role and contributing to MHC of the South African population. Their beliefs concerning the role of the RC included the RC as first port of call for psychological assistance and appropriate referral, the MH professional tasked with psycho-education, working within SOP of the RC, providing support for psychologists, and providing an accessible and affordable service. Two participants reported different perceptions of the role of the RC. One of these two participants reported that, in her experience, there was a lack of clarity about the role of the RC, and the other stated that, in her opinion, there was uncertainty about where to position the RC in the field of MH.

Studies that researched the role of the RC confirmed that RC's were engaged in PMHC, with a focus on the prevention of MH issues and the promotion of MH and MHC (Elkonin & Sandison, 2006; Fisher, 2017). Studies also revealed the same

belief that the RC is more affordable than other MH professionals such as psychologists (Abel & Louw, 2009; Mashiane, 2020; Rouillard et al., 2016). The cost-effective services of the RC makes them more accessible to the public than psychologists, making them ideal candidates to provide PMHC.

In terms of their automatic motivation, which includes emotion, most participants in this study were passionate about the delivery of MHC to diverse and under-resourced communities in the country. These participants stated that they were keen and excited about providing PMHC, and reiterated that they were committed to their clients and their practices. This is in line with other studies which reported RCs' interest in and commitment to PMHC as facilitators in their delivery of PMHC (Fisher, 2017; Rouillard et al., 2016). Fisher (2017) and Roulliard et al. (2016) and reported that most RCs wanted to be part of the MH profession, and assist those in need of MHC.

Post 1994, South Africa's National Mental Health Policy Framework and Strategic Plan 2013-2025 called for the integration of MHC into PMHC. The National Health Insurance (NHI) system was adopted to provide all South Africans with with Universal Health Cover (UHC) (White Paper NHI 2003), and was tasked with developing the guidelines for the migration of MHC into PMHC, especially in under-resourced communities (Matlala, 2018). Although there has been some progress since 1997, there are still debilitating MH service delivery gaps throughout the country (Petersen et al., 2009). The situation was exacerbated by the dearth of MH resources, which included MH professionals. There are no psychiatrists in most rural public health facilities (De Kock & Pillay, 2017). This has lead to over-stretched primary health care (PHC) physicians and PHC MH nurses becoming responsible for the psychopharmalogical treatment of MH patients (De Kock & Pillay, 2016). Of the 2789 clinical psychologists registered in 2014 in South Africa, 1213 worked in the public sector at the rate of 2.6 per 100,000 population (Day & Gray cited in De Kock & Pillay, 2017). By 2015, research established that there were 466 psychologist too few in the country (Bateman, 2015). This low-resourced workforce of MH professionals (De Kock & Pillay, 2016), as well as the many vacant positions for psychologists and psychiatrists that remain unfilled (Pillay & Laher, 2018), add to the strain and overburdening of MH service provision in South Africa.

The creation of the category of RC, signed into law in 2003, was to address the treatment gap between the lack of resources, which included the insufficient number

of MHC professionals, and the population in need of MHC in South Africa (Burns, 2011). However, the lack of recognition by government and the lack of employment of RCs in the public sector to resolve the treatment gap has only exacerbated this situation. In this study, the capabilities and motivation of the participants to provide PMHC in low resourced communities did not meet with the opportunities to do so.

5.2.3 Lack of Opportunity as a barrier (Environmental context and resources, social influences)

The government's rationale for the creation of the RC category and training of RCs was to establish a MH professional who would provide MH services in diverse populations and enhance the well-being of communities (HPCSA, Form 258, 2019). This I identified as the target behaviour for RCs. In this study, participants indicated that they were adequately trained, skilled and motivated to provide this service to South African communities. This has not happened as there was a lack of physical and social opportunities to do so. The opportunity component of the COM-B model is the context, the external factors outside of the individual, that also influence or prompt behaviour. The COM-B model allots equal value to the three components in their regulation of behaviour. This means that the opportunity (external factors) and the intra-psychic elements such as capability and motivation all influence behaviour (Michie et al., 2011), and are all equally important in determining a target behaviour.

RCs in this study could not demonstrate the target behaviour of providing PMHC to communites as the context failed to provide them with opportunities to do so. The barriers to RCs providing PMHC were primarily located in their environment. I identified two key environmental barriers to the delivery of PMHC by RCs. These are the lack of knowledge and recognition of the RC by government, MH and health professionals and communities, and few or no employment opportunities in the public sector with the preference of government to employ psychologists and social workers. Further barriers were identified in the realm of social influences, and included a lack of support by other MH and health professionals, and negative perceptions and attitudes of other MH professionals, especially psychologists.

5.2.3.1 Environmental barrier: lack of knowledge and recognition

Participants in this study reported that, in their experience, the RC was a largely unknown MH professional. They stated that there was a lack of knowledge about the role and SOP of the RC, and a lack of recognition and engagement of RCs. Participants experienced this lack of knowledge and recognition as a barrier to

their delivery of MHC to both under-resourced and resourced communities. They identified the bodies and structures that did not know about them or recognise them as government departments, including Departments of Health, government institutions such as hospitals, schools and clinics, communities, the HPCSA, medical aids, some NGOs, and practitioners in the MH and health fields. Participants in this study reported that the oversight led to no or limited opportunities for RCs to provide MHC or PMHC. They described the lack of opportunities such as being excluded from the health and MH referral system, little if no engagement of their services, limited or no employment in the public sector, limited support from schools, being forced to take on extra employment which was unrelated to MH or MHC to make a livelihood, and confusion with lay counsellors.

Other studies reported this barrier. Mashiane (2019) reported the lack of recognition alongside the confusion with other MH professionals, and Fisher (2017) found that the confusion of RCs with other MH professionals or lay counsellors undermined the RC's sense of professional identity. Abel and Louw (2009) reported this barrier as one of primary concern for RCs nationwide, and, along with Elkonin and Sandison (2006) and Kotze and Carolissen (2005), identified the need for government, other MH and health professionals and the public to be educated about RC role and SOP, and the profession to be marketed.

5.2.3.2 Environmental barrier: lack of employment opportunities and consequences

Participants in this study could not demonstrate the target behaviour as a result of contextual barriers. Participants stated that the most significant barrier to their delivery of PMHC was the lack of employment opportunities in the public sector. When a target behaviour does not occur, the analysis of the elements of a theoretical framework such as the COM-B model helps to identify what needs to change for the target behaviour to occur (Barker et al., 2016). In this study, it is clear that the component that needs to be analysed to facilitate the required target behaviour is the opportunity component of the COM-B model, in particular, environmental context and resources, and social influences.

The majority of participants in this study reported that they had responded to government's directive that RCs would help scale up the MH services in various communities in South Africa. They reported that they felt adequately trained, skilled and motivated to do so, but that employment opportunities in government institutions and structures had not materialized. Participants explained that, in their experience,

the lack of positions for RCs was a result of government's lack of recognition and understanding of the category, and the preferred funding and employment of psychologists and social workers by government. Participants cited examples of a lack of positions for RCs at schools, hospitals, clinics, community health centres and government departments, despite the fact that government policy regarding RCs stipulated that RCs are to be employed in these contexts (Form 258, 2019). While some participants in this study reported that they could not secure employment at public schools, public hospitals, primary health care centres and clinics, others reported securing only part-time positions at these institutions. They concurred that, in their opinion, government preferred to appoint psychologists and social workers in these institutions. Some participants expressed their frustration and disappointment with government because they were deprived of the opportunities to provide accessible and affordable MHC assistance in low resourced communities.

Although RCs as MH professionals demonstrated that they had acquired the core competencies as stipulated by the Health Professions Board (Rouillard et al., 2016), were adequately trained and keen to assist with MHC (Fisher 2017; Rouillard et al., 2016), it has been reported throughout the relevant literature that there were no or very few positions for RCs in the public sector (Abel & Louw, 2009; Elkonin & Sandison, 2006; 2010; Fisher, 2017; Rouillard et al., 2016). Participants in a study by Elkonin and Sandison (2006) related that finding employment was almost impossible. According to Fisher (2017), research revealed that more than 80% of RCs could not find employment. This meant that RCs could not make vital and essential MH services more accessible and affordable to under-resourced communities (Elkonin & Sandison, 2006; Rouillard et al., 2016). It was also reported that there was a lack of employment opportunities for RCs as social workers were preferred to fill these posts (Elkonin & Sandison, 2006; Kotze, 2006; Mashiane, 2019; Vala, 2017).

Almost all the participants in this study reported that the lack of employment opportunities in the public sector funnelled them into private practice. The majority of participants in this study, who could not find employment in government institutions and structures, did not relish the idea of private practice. They cited various reasons for this including that for some of them it was difficult, if not impossible, to provide PMHC from their private practices as they often had to only assist clients who had medical aid cover so that they could sustain their practices and make a living. Some

participants added that they were not trained and skilled to run private practices. These participants reported that their formal training did not include the development of any entrepreneurial skills, and this made the establishing and maintaining of a private practice difficult. Furthermore, their private practices often did not provide sufficient income so they had to take on extra employment to ensure a livelihood for them and their families. Participants regarded the extra employment as another barrier to their delivery of PMHC as the employment was often not in the field of MH, it was time-consuming and draining, and sometimes corroded their passion for the RC profession.

Participants in this study reported that the lack of employment opportunities and the subsequent difficulties left them feeling abandoned by government, irrelevant, frustrated, disappointed, inadequate, uncertain, and with a sense of letting communities in need of MHC down. Some participants reported fellow trained colleagues who had left the profession, and admitted that they too had considered this option at times.

Several studies reported that the lack of employment opportunities for RCs left them limited options other than private practice to make a living (Abel & Louw, 2009; Elkonin & Sandison, 2006; Fisher, 2017; Rouillard et al., 2016). According to Fisher (2017), RCs in private practice increasingly focused on one-on-one counselling and, operating mostly in urban areas in the country, they serviced the more privileged citizen rather than the communities that they were intended to assist. The lack of positions for RCs also made many trained graduates leave the MHC field, and enter professions not related to this field (Abel & Louw, 2009; Fisher, 2017; Mashiane, 2019; Rouillard et al., 2016).

For a minority of the participants in this study, private practice was a welcome, if challenging, option. These participants did not, however, regard the delivery of PMHC as their primary task. Their practices were in resourced communities, and focussed on wellness, sport, sexual education and sexual well-being, anger management, ADHD counselling and self-awareness.

An encouraging, if hampered finding in this study, was that the majority of participants in this study could provide some kind of PMHC from their private practices, although, at times, without remuneration. These participants reported that they provided PMHC in under-resourced communities, especially psycho-education about MH and MHC, and supportive counselling. They did so via workshops,

presentations, radio talk shows, free wellness days and EPA programmes. Some participants revealed that they provided PMHC pro bono, by volunteering in communities, or by reducing their fees. However, most of them could only provide the unremunerated and reduced fee service because they had taken up part-time employment to supplement their incomes. They stated that without the extra income, pro bono and voluntary PMHC was not sustainable. One participant reported that he could provide all his services pro bono, and could do so because he was retired with an income. In her study, Fisher (2017) also established that for RCs do volunteer work in communities was not sustainable if the profession was to provide them with a livelihood. When employed, RCs indicated that they earned far too little, and were forced to supplement their incomes (Fisher, 2017).

5.2.3.3 Social barrier: lack of support and negative bias

According to the majority of participants in this study, the lack of knowledge and understanding of the RC translated into a lack of support from and negative bias by other MH and health professionals when they, as RCs, endeavoured to provide PMHC. They identified these developments as further barriers to their delivery of PMHC. With regards to a lack of support, they stated that, in their opinion, other MH and health professionals did not support RCs because they regarded RCs as a threat to their livelihood and their professions. They reported that, in their experience, the protection of professional turf and resources among MH professionals, in particular, led to the exclusion of the RC and their contribution to PMHC in the MH field.

Participants reported that the lack of support also translated into the other MH and health professionals not engaging the services of RCs. Some participants stated that they had made MH and health practitioners aware of their professional services and practices, sometimes in close proximity, but they were not included in the relevant referral systems. Participants allotted this lack of engagement by their MH and health colleagues to a lack of knowledge of the RC role and scope of practice, and a lack of interest in RCs. A participant related that, in his opinion, psychologists and RCs would always operate as separate, unrelated entities in the MH field. This participant, along with some others, revealed that he had hoped for a referral system between RCs and psychologists that resembled that of general practitioners (GP) and specialists, with reciprocal referrals as the norm.

My findings corroborate those of previous research. Able & Louw (2009) and Fisher (2017) found that there was a lack of referrals to RCs from other MH and health professionals, and that RCs felt that other professionals questioned their qualifications and abilities as MH professionals. Along with limited referrals to RCs, other MH health professionals also regarded RCs as a perceived threat and in direct competition with them (Abel & Louw, 2009; Elkonin & Sandison, 2006).

Furthermore, some participants reported that, in their experience, other MH and health professionals demonstrated negative attitudes and perceptions of RCs, and for them, this was a further obstacle to the rendering of their services. These participants related that, in their opinion, other MH and health professionals did not value RCs, and largely regarded the RC as an inferior and illegitimate MH practitioner. They added that psychologists, in particular, were unnecessarily suspicious about RCs operating outside of the RC scope of practice, and were reluctant to interact with RCs. These participants stated that this unfavourable bias impacted negatively on their reflective and automatic motivation to deliver PMHC. In terms of their motivation, they reported that they felt disempowered and inadequate in their role as RC, and, at times, considered leaving the profession, especially when they continually had to fight for recognition and engagement by government, other MH and health professionals, and communities. They explained that their confidence was undermined, and accompanying emotions included frustration, anger, disillusionment, and an erosion of their passion for their profession.

Several studies reported similar findings. Studies found that RCs had negative feelings about being overlooked and unacknowledged by the private and public sector (Fisher, 2017; Mashiane, 2020; Vala, 2017). In these studies, RCs felt inferior, disrespected and uncertain as a result of the confusion and lack of acknowledgement of their abilities and their role as MH professionals. Studies also reported that RCs felt disappointed and disillusioned with the profession (Elkonin & Sandison, 2006; Fisher, 2017; Vala, 2017), so much so that many RCs left the profession and the field of psychology (Fisher 2017; Vala, 2017).

A minority of participants stated that they personally were not negatively affected by the lack of support and engagement by government and other MH and health professionals as they worked in multi-disciplinary teams and support groups, and so benefitted from internal referrals, support and engagement.

An interesting finding was that, although the majority of participants in this study reported that they were negatively affected by the lack of recognition, support and engagement, some participants revealed that the oversight prompted them to positive and enhancing action. The majority of the participants had either read or were engaged in a master's degree, primarily in psychology, and one participant had read a doctorate in the field of MHC. Others reported that they were proud of their work and continued acquiring skills, worked within their SOP, and had developed or were developing a niche in the psychology profession.

Other studies reported that, despite experiencing the oversight as a barrier to their delivery of PMHC, the majority of RCs still choose to remain in the profession, and highlighted benefits such as valuable practical experience, the option to have a private practice and be self-employed, and personal development and growth (Abel & Louw, 2009; Fisher, 2017).

5.3 Conclusion

For the target behaviour of the RC to be achieved, i.e., that of the MH professional who provides supportive counselling, psycho-education, screening and assessment, and appropriate referral in diverse and under-resourced communities, changes will have to be made to the physical and social opportunities in their environment. In this study, the changes that will have to be made to the opportunities for RCs would include greater knowledge about the RC role and SOP, the recognition, engagement and respect of RCs by other MH and health professionls and communities, as well as a decided increase in the employment opportunities for RCs in the public sector. The COM-B model and the TDF provided a theoretical understanding of behaviour so that it is clear which component or components of the behaviour model required intervention to facilitate the target behaviour (Michie et al., 2011).

Chapter 6

Summary of Key Findings, Limitations, Recommendations and Conclusion

6.1 Introduction

This chapter includes a summary of the key findings, the limitations of the study, recommendations for future research and practice, and the conclusion.

The aim of this study was to explore the barriers and facilitators that registered counsellors (RCs) in private practice experienced when they provided or attempted to provide primary mental health care (PMHC) to diverse and under-resourced communities in South Africa. I used semi-structured interviews to gather data from 19 participants who were RCs in full-time or part-time private practice. I employed thematic analysis to uncover three important themes in the data, namely that RCs had (1) a positive disposition to engaging in community work, (2) the RC was an unacknowledged mental health professional, and (3) RCs had limited options other than private practice. I regarded the first theme as a facilitator of the delivery of PMHC by RCs in private practice as participants reported that they felt competent to provide PMHC, were confident about the value of their role as mental health professionals, and were aware of the dire need of PMHC. I regarded the other two themes as barriers to this endeavour. Participants related that there was a lack of knowledge and recognition of the RC and, hence, no or very little support or engagement of them and their services by government, other mental health and health professionals, and communities. Furthermore, participants reported that the lack employment opportunities in the public sector funnelled many of them into private practice from which it was difficult, if not impossible, to provide PMHC.

6.2 Theory used to frame and make sense of the findings

I used the Capability, Opportunity, Motivation (COM-B) model, at the heart of the Behaviour Change Wheel (BCW), (Michie et al., 2011) and the Theoretical Domains Framework (TDF) (Smith et al., 2019) to understand the behaviour of the participants in relation to their delivery of PMHC to diverse and under-resourced communities, the target behaviour of this professional category. The COM-B model postulates that behaviour (B) is the result of the interaction between an individual's physical and psychological capabilities when they engage physical and social opportunities as a consequence of their motivation and emotions. I employed the TDF to provide a more granular understanding of the components of the COM-B model, and to facilitate a more detailed assessment of the barriers to and facilitators

of the target behaviour (see Chapter 2). A detailed understanding of the barriers and facilitators can be used to design and implement appropriate interventions to facilitate change (Smith et al., 2019).

Participants reported that they were capable and motivated to provide PMHC to diverse and under-resourced communities. They linked their capability and motivation to their training, knowledge and skills to deliver PMHC, their awareness of the great need for PMHC, their clear understanding of their professional role, and their beliefs about their capabilities. These attributes I regarded as facilitators of the delivery of PMHC. Barriers reported by the participants were linked to the lack of social and environmental opportunities that participants experienced. These barriers included the lack of recognition of the RC by other health professionals, government and the public, and the lack of employment opportunities in the public sector where they would be able to provide PMHC.

6.3 Summary of key findings

The objectives of this study were to explore the current practices of RCs in private practice, in particular, their perceptions of their knowledge, skills and motivation to provide PMHC, and the opportunities afforded them to do so.

All the participants in this study reported that they felt competent to provide PMHC because they had the relevant knowledge and skills to do so. Participants confirmed that their services were in line with the RC scope of practice, and included supportive counselling, psycho-education, screening, assessment and appropriate referral. Participants also reported that they were aware of the dire need for PMHC in low-resourced communities.

A more granular understanding of motivation on the COM-B model is provided by the TDF (Smith et al., 2019). According to the TDF, motivation includes participants' beliefs about their capabilities, their understanding of their professional role and identity, their optimism, and their beliefs about consequences. The majority of participants reported that they had positive beliefs about their capabilities and could, therefore, fulfil their roles as mental health professionals. I regarded the capabilities and motivation of the participants as facilitators of their inclination and desire to provide MHC and PMHC to diverse and under-resourced communities in South Africa.

Although participants in this study reported that they were adequately trained, skilled and motivated to provide PMHC, there was a lack of opportunities to do so.

The COM-B model posits that all three components of capability, motivation and opportunity are equally important in determining a target behaviour. RCs in this study could not demonstrate the target behaviour as the environment failed to provide them with opportunities to do so. I regarded this as a barrier to the delivery of PMHC by RCs. Two key barriers in the environment were a lack of knowledge and understanding of the RC by government, mental health and health professionals and the public, and few or no employment opportunities in the public sector.

Participants reported that the lack of employment opportunities in the public sector was the most critical barrier to their delivery of PMHC. Participants allotted the lack of employment opportunities to government's lack of recognition and understanding of the RC category, and government's preference for funding and employing psychologists and social workers.

The majority of participants stated that the lack of employment opportunities funnelled them into private practice, often unwillingly. Most of these participants were not keen on private practice as private practice made it difficult, if not impossible, for them to deliver PMHC. Participants reported that the lack of employment opportunities and the resultant challenges made them feel abandoned by government, and concerned that they had let down communities in need of mental health care.

An encouraging finding was that the majority of participants provided some form of PMHC from their private practices, often enough without remuneration, however. These participants reported that they provided PMHC via workshops, presentations, radio talk shows, free wellness day and EPA programmes. They did this alongside working pro bono, reducing their fees and volunteering in communities.

Another lack of opportunity to deliver PMHC was in the realm of social influences. This barrier comprised the lack of support and negative bias from other mental health and health professionals. Participants reported that this negative and unsupportive stance rendered them feeling disempowered and frustrated.

It was clear that for the target behaviour of the RC to be achieved, changes would have to be made to the physical and social opportunities in their environment. These changes would include extensive knowledge and promotion of the role and scope of practice of the RC, recognition, engagement and support by government,

other mental health and health professionals, and communities, and a large-scale increase in employment opportunities for RCs in the public sector.

6.4 Limitations of the study

The first limitation of this study was the small sample size and the use of convenience sampling meaning that the sample may not have been representative of the target population. However, interviews were in-depth and yielded rich data and sampling took place until saturation was achieved. It is important to note that the representativeness of samples is not required in qualitative research (Omona, 2013).

The second limitation to the study was that interviews were only conducted in English and Afrikaans. This meant that RCs, who were proficient and confident in other languages but not in English or Afrikaans, could not participate in the study. There was, however, a varied representation of ethnicity among the participants of the study.

A third limitation was that the majority of participants were based in urban areas. This skewed a more representative sample of a national deployment of RCs in both urban and rural areas, and limits transferability of the study. This may also reflect a lack of RCs in rural areas.

6.5 Recommendations

Several recommendations can be made based on this research. These recommendations apply to future research and practice.

6.5.1 Recommendations for researchers conducting similar studies

Further research could engage the Behaviour Change Wheel (BCW), which has the COM-B model at its centre, to identify and explore relevant interventions and policies that would address the lack of physical and social opportunities for RCs to deliver PMHC to diverse and under-resourced communities. Future studies could include the perspectives of other mental health and health professionals about the role and value of RCs as mental health professionals, and the contribution they make to the profession of psychology in South Africa. The experiences of other mental health and health professionals may be different to the perceptions of them as purported by RCs**.**

Future studies could investigate the inclusion of supervised practical experience in PMHC during the academic training of RCs at all tertiary institutions, instead of leaving this element to their practicums / internships only. Further research could focus on the inclusion of a business management module in the

academic curriculum of the RC as this would help to prepare them for the option of private practice. Future studies could investigate the very limited representation of RCs on important, relevant regulatory bodies, focusing on the barriers and facilitators to this kind of involvement.

6.5.2 Recommendations for practice and organizational policy

Recommendations for future practice could include government employment of an RC at every community health centre and clinic in the country. This would make it possible for the RCs to provide community accessible PMHC, would help reduce the stigma attached to mental health conditions, and so normalise consultation with mental health professionals. The same could be done at government schools, especially at schools in under-resourced and marginalised communities. This practice would constitute the promotion and marketing of the RC category and scope of practice by government, the tapping of the confirmed potential of the RC, and prevent the loss of this important mental health human resource.

Furthermore, tertiary institutions could ensure that all internship / practicum sites are in under-resourced communities. This would facilitate familiarisation with RCs' intended target population, and the development of relevant skills to provide PMHC. Further practice could include the development and accreditation of Continuous Professional Development (CPD) programmes that are specifically aimed at the RC category and scope of practice, and are available at lower fees for RCs who earn less than psychologists.

Finally, further practice could promote and ensure engagement between RCs and psychologists via integrated conferences, public forums and support groups. This would help to increase the sharing of knowledge and recognition of RCs, and could increase the engagement of RCs and their services.

6.5.3 Contribution to the Subject and Body of Knowledge

The aim of this study was to identify and explore the barriers and facilitators that RCs in private practice encountered as they provided or attempted to provide PMHC to diverse and low-resourced communities. The findings of the study may prompt a reconsideration of the value and critical importance of the category, particularly by government, other mental health and health professionals, community organizations, and communities given the reported capability and motivation of RCs to assist in the field of mental health care.

6.6 Conclusion

The facilitators and the barriers to the delivery of PMHC by RCs in private practice were identified and explored in this study. The facilitators were related the appropriate training, adequate knowledge, skills and passion of RC to render this service. The barriers were located in the lack of physical and social opportunities, in particular, the lack of employment opportunities in the public sector, and the lack of recognition, understanding and engagement of this mental health professional.

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Appendix A

Letter of permission to recruit participants ARCSA

ARCSA
making psychological services accessible
Association of Registered Counsellors in South Africa

www.arcsa.org.za
assocrcsa@gmail.com

29 July 2019

Dear Greer,

Following your request of 18 July 2019, ARCSA is able to assist in the following ways:

- email the electronic invitation flyer once at the start of the recruitment process to registered counsellors on our membership list
- the student, Greer Salt, may post the electronic invitation flyer on the ARCSA website once a month for the duration of three months
- the student, Greer Salt, may post the electronic invitation flyer on the Whatsapp Support Group once a month for the duration of three months.

Yours in Mental Health,
Delia Strondl
for and on behalf of ARCSA

Appendix B

Letter of permission to recruit participants PsySSA

Psychological Society of South Africa

Email: info@psyssa.com
Website: www.psyssa.com
Address: Oakhurst Business Park
Northwing, Ground floor
11/13 St Andrews Road
Parktown
2193
South Africa
Tel: +27 11 486 3322
NPO: 013-083

PsySSA
Psychological Society of South Africa

1 November 2019

To whom it may concern,

Re: Access to PsySSA Registered counsellor and Psychometry Division

Mrs Greer Salt, a paid PsySSA member, has been granted permission to have access to the PsySSA Registered counsellors and Psychometry Division database.

Should you require any further information, please do not hesitate to contact the PsySSA office.

Sincerely,

Ms Fatima Bhamjee
Executive Director: Psychological Society of South Africa

Appendix C

Consent form

Participant Information Leaflet and Consent Form

Title of the Research Project:

Exploring perceived barriers and facilitators to the delivery of primary mental health care in under-resourced communities in South Africa by registered counsellors in private practice.

Reference Number:

Principle Investigator:	Greer Salt
Address:	7 Stream Road Pringle Bay 7196
Contact Number:	084 406 0261
Email address:	greer.salt@gmail.com
Supervisor:	Dr Rizwana Roomaney
Address:	Department of Psychology Stellenbosch University Room 2027, RW Wilcocks Building, Ryneveld Street, Stellenbosch, 7600
Contact Number:	021 808 3973
Email address:	rizwanaroomaney@sun.ac.za
Co-supervisor:	Ms Mariam Salie
Address:	Department of Psychology Stellenbosch University Room 2019, RW Wilcocks Building, Ryneveld Street, Stellenbosch, 7600
Contact Number:	021 808 3552
Email address:	mariamsalie@sun.ac.za

1. INVITATION TO PARTICIPATE IN THE STUDY

You are invited to take part in a study that I, Greer Salt, a Master's student at the Department of Psychology at Stellenbosch University, will conduct. You have been approached to participate in this study because you are a registered counsellor in private practice in South Africa. Please take some time to read the information presented here as it will explain the details of this project. You can contact me if you need any further explanation or clarification about any part of the project.

This study has been approved by the **Research Ethics Committee** at **Stellenbosch University**, and will conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, South African Guidelines for Good Clinical Practice, and the Medical Research Council (MRC) Ethical Guidelines for Research.

2. PURPOSE OF THE STUDY

This study aims to explore the barriers to and facilitators of the delivery of primary mental health care (PMHC) to under-resourced communities in South Africa by registered counsellors (RCs) in private practice. This means that the study will explore and try to understand your experience of what makes it easy or difficult to provide primary mental health care to diverse communities in South Africa.

3. WHAT WILL BE ASKED OF ME AS A PARTICIPANT

If you agree to participate in this study, the following will happen

- you will be contacted to arrange an interview with me at a time that suits you
- interviews will also be conducted after hours if that is what works for you
- the interviews will be conducted only via Skype or telephonically
- the SKYPE and telephonic interviews will be conducted from my private and secure consulting room to ensure your privacy and the confidentiality of the conversation
- you too will be asked to engage the interview from a private and secure space to ensure confidentiality of the conversation
- you will read this information leaflet and consent form, or I will read it to you should you prefer that
- we will make sure that you fully understand the contents of this document, and then you will asked to sign it, scan it, and email to me at

greer.salt@gmail.com or WhatsApp it to me if that is more convenient for you

- the interview will last no longer that 60 minutes, and you will be asked about your experiences in relation to providing mental health care to under-serviced diverse communities in South Africa.

4. POSSIBLE RISKS AND DISCOMFORTS

There are no foreseeable risks to your participating in this study.

Also please note that your participation is entirely voluntary. You are free to decline to participate, and this will not affect you in any way negatively. If you do agree to participate, you will be free to stop the interview at any time, and you will be free to leave the study at any time even if you agreed to participate.

Should you, at any time, during the interview experience any discomfort or distress, we will discuss this, and engage the appropriate action such as counselling or therapy to resolve this.

You will be asked whether you would like information about the study once it is done, and this will be noted and the information sent to you.

What will your responsibilities be?

It will be your responsibility to ensure that your participation in the study alongside your work or family commitments is possible, and that you can commit to the interview on the date and at the time that we agree on.

5. POSSIBLE BENEFITS TO YOU AS A PARTICIPANT AND/0R SOCIETY

There is no financial benefit to you for participating in this study. However, your participation and the information you relay will assist with the understanding of the role the registered counsellor in private practice does or can play in providing mental health care to diverse communities in South Africa.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

- Your identity and any information that you share with me will be protected and remain confidential.
- The use of a pseudonym instead of your real name and surname will ensure your anonymity throughout the study.
- The interview will be audio-recorded, and only I and my supervisors will have access to the recording.

- The information you relay during the interview will be transcribed by me, and will be stored on my password protected laptop, and, other than I, only my supervisors will have access to the transcription.
- Should you at any time withdraw from the study, the audio-recording of your interview as well as the transcribed data will immediately be destroyed.
- All data will be destroyed five years after completion of study.

7. PARTICIPATIONS AND WITHDRAWAL AND RIGHTS OF PARTICIPANTS

I reiterate that you can choose whether to participate in this study or not. If you do agree, you may withdraw at any time without any negative consequences to you. You may also refuse to answer any questions you don't want to answer and still remain in the study.

8. RESEARCHER'S CONTACT INFORMATION

- If you have any questions or concerns about this study, please contact me, Greer Salt, at 084 406 0261 or at greer.salt@gmail.com
- You can also contact either or both of my supervisors:
  Dr Rizwana Roomaney at (021) 808 3973 or at rizwanaroomaney@sun.ac.za
  Ms Mariam Salie at (021) 808 3552 or at mariamsalie@sun.ac.za
- You can contact the Research Ethics Committee at (021) 938 9185 if you have any questions or concerns that have not been properly dealt with by me, the primary investigator.
- You are requested to keep the information leaflet and consent paper in a safe place.

DECLARATION OF CONSENT BY THE PARTICIPANT

By signing below, I, ……., agree to take part in this research study entitled: Exploring the perceived barriers to and facilitators of the delivery of primary mental health care to under-resourced communities in South Africa by registered counsellors in private practice, as conducted by Greer Salt.

I declare that

- I have read or had read to me the information leaflet and consent form, and that it was in a language that I could understand and am comfortable with.
- I have been given the opportunity to ask questions and my questions have been adequately answered.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.
- I have been informed and I understand that taking part in this study is voluntary and I have not been forced to participate.
- I know that I may leave the study at any time and that this will not affect me negatively in any way.
- I understand that I may be asked to leave the study if it suggested by the primary investigator or her supervisors that participating is not in my best interests, or if I do not follow the research plan as I agreed to.

…… ……...

Signature of Participant **Date**

DECLARATION BY THE PRINCIPAL INVESTIGATOR

I, ……, as the **principal investigator**, declare that

- I explained the information contained in this document thoroughly to the participant.
- I provided the opportunity for the participant to ask questions and answered these adequately
- I am satisfied that the participant sufficiently understands all the aspects of the research study as related above
- I did not use an interpreter.

…….. ……

Signature of Principal Investigator **Date**

Appendix D

Interview schedule with registered counsellors in private practice

Title of the research

Exploring perceived barriers and facilitators to the delivery of primary mental health care in under-resourced communities in South Africa by registered counsellors in private practice

INTRODUCTION

The purpose of this interview is to explore the perceived barriers and facilitators to the delivery of primary mental health care (PMHC) in under-resourced communities by registered counsellors (RCs) in private practice in South Africa. This exercise would assist with the identification of interventions and policies that would facilitate this healthcare endeavour. I am going to ask you a few questions about your experience of delivering PMHC to under-resourced communities in South Africa, and what you experience as barriers and facilitators to your delivery of this service. Please take your time to answer the questions, providing as much or as little information as you feel comfortable sharing. The information that you share will be treated as confidential. If at any time you would like to end this interview, you are free to do so.

PART A

Can you tell me a little about yourself and your practice?

PART B

1. Do you think you have the knowledge and skills to deliver PMHC to under-resourced communities in this country?

   Prompts: How does your training to be an RC help you deliver this service? What do you think are the skills that you have or need to deliver this service? What do you think about your own competence and ability to do this work? Do you feel that you are being pressured to provide this kind of service? If so, why? If not, why not? How do you feel about working in private practice when the RC category was introduced to provide community-based mental health practitioners? Do you experience any conflict within yourself about providing or not providing PMHC to under-resourced communities? Is there any intergroup conflict about delivering this service? Could your elaborate? What resources do you have to deliver PMHC to under-resourced communities?

How do you feel about the way the RC has been prepared to deliver PMHC to under-resourced communities?

2. What do you think are the environmental factors that do or could influence your delivery of PMHC to under-resourced communities?
   Prompts: What in your environment makes it possible or easy for you to deliver PMHC to under-resourced communities? Could you elaborate on these enablers? What are the stressors related to this? What in your environment makes it difficult to deliver PMHC to under-resourced communities? How do you feel about these barriers? What are the stressors related to not being able to deliver this service? What about these things would you change or want to see changed to make it easier for you? Are there particular interventions that would help? Could you tell me more about these? Who do you think should be responsible for these interventions? Are there any policies – governmental or other – that you think could make things easier for you to deliver PMHC to under-resourced communities?

3. Can you tell me what personally motivates you or would motivate you to deliver PMHC to under-resourced communities?
   Prompts: How do you feel about being the mental health worker that is tasked with the delivery of PMHC to under-resourced communities? Can you elaborate on those feelings? How does providing or not providing this service make you feel about yourself? How does it feel to be part of the RC group of MH practitioners, and not, for example, part of the group of clinical or counselling psychologists? How do you feel about what other health professionals think about this role of yours? How does what other health professionals think about your role affect the way your feel about yourself? How does this affect the way you work?
4. What are some of the things that contribute to your sense of professional identity as a RC tasked with the delivery of PMHC to under-resourced communities?
   Prompts: What are your beliefs about the value of this role? What are some of the goals and plans that you have to fulfil the role? How do you go about making decisions that affect this professional role? How would you explain

your professional role and this task to others? Is the delivery of PMHC to under-resourced communities what RCs really want to do / need to do?

5. Do you have anything else that you would like to add? Do you have any questions?

Appendix E
Research Ethics Committee letter of approval

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

NOTICE OF APPROVAL

REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

24 April 2020

Project number:
14630

Project Title: Exploring perceived barriers and facilitators to the delivery of primary mental health care in under-resourced communities in South Africa by registered counsellors in private practice.

Dear Ms GREER Salt

Your REC: Social, Behavioural and Education Research (SBER) - Initial Application Form submitted on 13 April 2020 was reviewed and approved by the REC: Social, Behavioural and Education Research (REC: SBE).

Please note below expiration date of this approved submission:

Ethics approval period:

Protocol approval date	Protocol expiration date
24 April	23 April

GENERAL COMMENTS:

1) There is currently a **postponement of all research activities at Stellenbosch University,** apart from research that can be conducted remotely/online and requires no human contact, and research in those areas specifically acknowledged as essential services by the South African government under the presidential regulations related to COVID-19 (e.g. clinical studies).

2) Remote (desktop-based/online) research activities, online analyses of existing data, and the writing up of research results are strongly encouraged in all SU research environments.

3) The researcher should include the SU Logo on the informed consent form. [ACTION REQUIRED]

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: SBE, the researcher must notify the REC of these changes.

Please use your SU project number (14630) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

You are required to submit a progress report to the REC: SBE before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary).

Once you have completed your research, you are required to submit a final report to the REC: SBE for review.

Included Documents:

Document Type	File Name	Date	Version
Data collection tool	FINAL INTERVIEW SCHEDULE 25 Feb 2020	25/02/2020	
Proof of permission	ARCSA - Letter of permission to recruit RCs	25/02/2020	1
Proof of permission	PsySSA - Letter of permission to recruit via PsySSA	25/02/2020	1
Default	Masters student feedback report form[29987]	28/02/2020	
Informed Consent Form	REWORKED for REC RC Participant Info Leaflet and Consent Form 09 April 2020	10/04/2020	2

Research Protocol/Proposal	REWORKED for REC RESEARCH PROPOSAL 9 April 2020[26815]	10/04/2020 2
Recruitment material	REWORKED for REC FORMATTED MA ELECTRONIC FLYER 9 April 2020	10/04/2020 2
Default	MA REC MY RESPONSE LETTER TO MODIFICATIONS REQUIRED 08 April 2020	10/04/2020 1

If you have any questions or need further help, please contact the REC office at

cgraham@sun.ac.za. Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Social, Behavioral and Education Research

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.

The Research Ethics Committee: Social, Behavioural and Education Research complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Principal Investigator Responsibilities

Protection of Human Research Participants

As soon as Research Ethics Committee approval is confirmed by the REC, the principal investigator (PI) is responsible for the following:

Conducting the Research: The PI is responsible for making sure that the research is conducted according to the REC-approved research protocol. The PI is jointly responsible for the conduct of co-investigators and any research staff involved with this research. The PI must ensure that the research is conducted according to the recognised standards of their research field/discipline and according to the principles and standards of ethical research and responsible research conduct.

Participant Enrolment: The PI may not recruit or enrol participants unless the protocol for recruitment is approved by the REC. Recruitment and data collection activities must cease after the expiration date of REC approval. All recruitment materials must be approved by the REC prior to their use.

Informed Consent: The PI is responsible for obtaining and documenting affirmative informed consent using **only** the REC-approved consent documents/process, and for ensuring that no participants are involved in research prior to obtaining their affirmative informed consent. The PI must give all participants copies of the signed informed consent documents, where required. The PI must keep the originals in a secured, REC-approved location for at least five (5) years after the research is complete.

Continuing Review: The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is the PI's responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** Once REC approval of your research lapses, all research activities must cease, and contact must be made with the REC immediately.

Amendments and Changes: Any planned changes to any aspect of the research (such as research design, procedures, participant population, informed consent document, instruments, surveys or recruiting material, etc.), must be submitted to the REC for review and approval before implementation. Amendments may not be initiated without first obtaining written REC approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

Adverse or Unanticipated Events: Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the REC within **five (5) days** of discovery of the incident. The PI must also report any

instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants.

Research Record Keeping: The PI must keep the following research-related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence and approvals from the REC.

Provision of Counselling or emergency support: When a dedicated counsellor or a psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

Final reports: When the research is completed (no further participant enrolment, interactions or interventions), the PI must submit a Final Report to the REC to close the study.

On-Site Evaluations, Inspections, or Audits: If the researcher is notified that the research will be reviewed or audited by the sponsor or any other external agency or any internal group, the PI must inform the REC immediately of the impending audit/evaluation.